SERFF Tracking Number:	*LSVX-G127678989*	*State:*	*Arkansas*
Filing Company:	*USAble Life*	*State Tracking Number:*	*49937*
Company Tracking Number:	*AR000780100013*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Group Policy, GRP-P - Simmons First National Bank*		
Project Name/Number:	*Group Policy, GRP-P/AR000780100013*		

Filing at a Glance

Company: USAble Life

Product Name: Group Policy, GRP-P - Simmons First National Bank	SERFF Tr Num: LSVX-G127678989	State: Arkansas
TOI: L04G Group Life - Term	SERFF Status: Closed-Approved-Closed	State Tr Num: 49937
Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium	Co Tr Num: AR000780100013	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: SPI Life and Specialty Ventures	Disposition Date: 10/04/2011
	Date Submitted: 10/03/2011	Disposition Status: Approved-Closed
Implementation Date Requested: 10/03/2011		Implementation Date:

State Filing Description:

General Information

Project Name: Group Policy, GRP-P	Status of Filing in Domicile:
Project Number: AR000780100013	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 10/04/2011	
State Status Changed: 10/04/2011	Deemer Date:
Created By: SPI Life and Specialty Ventures	Submitted By: SPI Life and Specialty Ventures

Corresponding Filing Tracking Number:

Filing Description:

We are enclosing for your review and approval a Group Term Life and AD&D policy and related certificates. This is a single case filing to be issued to Simmons First National Bank. The forms are new and do not replace any forms previously approved by your department.

The Company address and phone numbers have been marked as variable so that they may be changed as necessary.

SERFF Tracking Number:	*LSVX-G127678989*	*State:*	*Arkansas*
Filing Company:	*USAble Life*	*State Tracking Number:*	*49937*
Company Tracking Number:	*AR000780100013*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Group Policy, GRP-P - Simmons First National Bank*		
Project Name/Number:	*Group Policy, GRP-P/AR000780100013*		

The policy, GRP-SIMMONS-P (5-09), is generic and intended for use with the enclosed Group certificates, which will be incorporated into and made a part of the aforementioned policy.

The following forms have been previously approved and can be used with these forms. They were approved on 2/18/2009 with Filing ID # 41419 (SERFF Filing ID # LSVX-126016440):

GADD-COMA (5-09) - Accidental Death & Dismemberment Coma Rider
GADD-E&D (5-09) - Accidental Death & Dismemberment Exposure & Disappearance Rider
GADD-REPT (5-09) - Accidental Death & Dismemberment Repatriation Rider
GADD-SBAB (5-09) - Accidental Death & Dismemberment Seat Belt - Air Bag Rider
GLABDSCLR (5-09) - Group Life Accelerated Benefit Disclosure
1000 (5-09) - Group Enrollment or Change Form
GMAPP (5-09) - Group Insurance Master Application
VGTL-APP (5-09) - Voluntary Group Term Life Enrollment Form
VADD-APP (5-09) - Voluntary Accidental Death & Dismemberment Enrollment Form
EOI (5-09) - Evidence of Insurability Application
GRP-DP-RDR (5-09) - Domestic Partner Rider
GRP-PORT-RDR (5-09) - Change Rider - Portability
GRP-PORT-APP (5-09) - Application for Portability of Group Term Life
GRP-PORTC-APP (5-09) - Application for Portability of Group Term Life
GRP-RLB-RDR (5-09) - Change Rider - Reduced Life Benefit

The following form has been previously approved and can be used with these forms. It was approved on 10/23/2008 with Filing ID # 40615 (SERFF Filing ID # LSVX-125864058):

APP-NOTICE (9-08) - Application Notice

USAble Life reserves the right to change the type style, paper size, and logo, or to issue the forms in electronic format. We also reserve the right to change our address or officers' signatures as necessary.

Company and Contact

Filing Contact Information

Rob Wittenburg, Regulatory Resource Analyst	rwittenburg@usablelife.com
PO Box 1650	501-212-8877 [Phone] 8877 [Ext]
Little Rock, AR 72203-1650	501-235-8484 [FAX]

SERFF Tracking Number:	*LSVX-G127678989*	*State:*	*Arkansas*
Filing Company:	*USAble Life*	*State Tracking Number:*	*49937*
Company Tracking Number:	*AR000780100013*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Group Policy, GRP-P - Simmons First National Bank*		
Project Name/Number:	*Group Policy, GRP-P/AR000780100013*		

Filing Company Information

USAble Life	CoCode: 94358	State of Domicile: Arkansas
PO Box 1650	Group Code: 876	Company Type: Life & Healh
Little Rock, AR 72203-1650	Group Name: Life and Speciality Ventures (LSV)	State ID Number:
(501) 375-7200 ext. [Phone]	FEIN Number: 71-0505232	

Filing Fees

Fee Required?	Yes
Fee Amount:	$550.00
Retaliatory?	No
Fee Explanation:	11 forms x $50 per form = $550
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
USAble Life	$550.00	10/03/2011	52398670

SERFF Tracking Number:	*LSVX-G127678989*	*State:*	*Arkansas*
Filing Company:	*USAble Life*	*State Tracking Number:*	*49937*
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TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Group Policy, GRP-P - Simmons First National Bank*		
Project Name/Number:	*Group Policy, GRP-P/AR000780100013*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/04/2011	10/04/2011

SERFF Tracking Number:	*LSVX-G127678989*	*State:*	*Arkansas*
Filing Company:	*USAble Life*	*State Tracking Number:*	*49937*
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Project Name/Number:	*Group Policy, GRP-P/AR000780100013*		

Disposition

Disposition Date: 10/04/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LSVX-G127678989*	*State:*	*Arkansas*
Filing Company:	*USAble Life*	*State Tracking Number:*	*49937*
Company Tracking Number:	*AR000780100013*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Group Policy, GRP-P - Simmons First National Bank*		
Project Name/Number:	*Group Policy, GRP-P/AR000780100013*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Form	Group Policy		Yes
Form	Group Certificate		Yes
Form	Group Certificate		Yes
Form	Group Certificate		Yes
Form	Group Certificate		Yes
Form	Group Certificate		Yes
Form	Group Certificate		Yes
Form	Group Certificate		Yes
Form	Group Certificate		Yes
Form	Group Certificate		Yes
Form	Group Certificate		Yes

SERFF Tracking Number:	*LSVX-G127678989*	*State:*	*Arkansas*
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Product Name:	*Group Policy, GRP-P - Simmons First National Bank*		
Project Name/Number:	*Group Policy, GRP-P/AR000780100013*		

Form Schedule

Lead Form Number: GRP-SIMMONS-P (5-09)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	GRP-SIMMONS-P (5-09)	Policy/Contract/Fraternal Certificate	Group Policy	Initial		51.400	GRP-SIMMONS-P (5-09).PDF
	GRP-SIMMONS-CL1 (5-09)	Certificate	Group Certificate	Initial		51.600	GRP-SIMMONS-CL1 (5-09).PDF
	GRP-SIMMONS-CL2 (5-09)	Certificate	Group Certificate	Initial		51.600	GRP-SIMMONS-CL2 (5-09).PDF
	GRP-SIMMONS-CL3 (5-09)	Certificate	Group Certificate	Initial		51.600	GRP-SIMMONS-CL3 (5-09).PDF
	GRP-SIMMONS-CL4 (5-09)	Certificate	Group Certificate	Initial		51.600	GRP-SIMMONS-CL4 (5-09).PDF
	GRP-SIMMONS-VADD-CL1 (5-09)	Certificate	Group Certificate	Initial		51.600	GRP-SIMMONS-VADD-CL1 (5-09).PDF
	GRP-SIMMONS-VADD-CL2 (5-09)	Certificate	Group Certificate	Initial		51.600	GRP-SIMMONS-VADD-CL2 (5-09).PDF
	GRP-SIMMONS-	Certificate	Group Certificate	Initial		51.600	GRP-SIMMONS-

SERFF Tracking Number:	*LSVX-G127678989*	*State:*	*Arkansas*
Filing Company:	*USAble Life*	*State Tracking Number:*	*49937*
Company Tracking Number:	*AR000780100013*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Group Policy, GRP-P - Simmons First National Bank*		
Project Name/Number:	*Group Policy, GRP-P/AR000780100013*		

VADD-CL3 (5-09)					VADD-CL3 (5-09).PDF
GRP-SIMMONS-VGTL-CL1 (5-09)	Certificate	Group Certificate	Initial	51.600	GRP-SIMMONS-VGTL-CL1 (5-09).PDF
GRP-SIMMONS-VGTL-CL2 (5-09)	Certificate	Group Certificate	Initial	51.600	GRP-SIMMONS-VGTL-CL2 (5-09).PDF
GRP-SIMMONS-VGTL-CL3 (5-09)	Certificate	Group Certificate	Initial	51.600	GRP-SIMMONS-VGTL-CL3 (5-09).PDF

USAble Life

[320 W. Capitol] • P.O. Box 1650 • Little Rock, AR 72203-1650
[(501) 375-7200 • (800) 648-0271]

POLICYHOLDER:
SIMMONS FIRST NATIONAL BANK

PREMIUM DUE DATE:
First Day of Each Policy Month

POLICY NUMBER:
50001328

ANNIVERSARY DATE:
September 1, 2011 and Each Succeeding September 1

EFFECTIVE DATE:
September 1, 2010

STATE OF DELIVERY:
ARKANSAS

USAble Life agrees with the policyholder to insure covered persons who are entitled to the insurance provided by this policy. This policy is issued in consideration of the application of the policyholder, and the payment of the first premium. The first premium is due and payable on the effective date of the policy. Subject to the policy's grace period provision, all premiums after the first must be paid when or before they are due.

This policy is a legal contract between the policyholder and USAble Life. PLEASE READ THIS POLICY CAREFULLY.

Signed for USAble Life:

James L. Tourse — Secretary

Jason Ram — President

Nonparticipating
Renewable
Group Term Life and Accidental Death & Dismemberment Insurance Policy

Table of Contents

Section 1 – Schedule of Insurance

Policyholder: SIMMONS FIRST NATIONAL BANK

Policy Number: 50001328

Policy Effective Date: September 1, 2010

Renewal Date: September 1, 2012

The Schedule(s) of Insurance for the Group Term Life and Accidental Death & Dismemberment Insurance Policy are shown in the Certificate(s) of Insurance.

The Schedule of Insurance will control the:

1. benefit amounts and maximum limits;
2. eligibility and effective date rules; and
3. other schedule amounts and limits,

which apply to the employees of the policyholder.

Section 2 – Associated Company

We will insure the eligible employees of the policyholder's affiliates or subsidiaries listed on the Group Insurance Application.

Newly Acquired Organizations

The policy applies only to the policyholder as composed on the effective date of the policy or as thereafter amended.

New employees acquired through merger, stock purchase, exchange of stock, or otherwise may be covered under the policy. Their coverage is subject to the following conditions:

1. that the policyholder report to us the name of the newly acquired organization along with any underwriting data we may need to determine the correct premium;
2. that we accept the newly acquired organization for coverage; and
3. that the policyholder pays the correct additional premium.

Coverage will start in accordance with the "Eligibility and Effective Date" provisions in the certificate. In no case, however, will coverage continue for more than 60 days after the acquisition or merger unless:

1. the required report has been made; and
2. the newly acquired organization has been accepted for coverage and the additional premium has been agreed on and paid.

The policyholder must pay for any period in which coverage is in effect.

Section 3 – Incorporation Provision

Certificate

The certificate(s) and the endorsement(s) or rider(s), which are attached to this policy are hereby incorporated in, and made a part of, this policy. If there is any conflict between the terms and conditions of this policy and an attachment, this policy shall be controlling.

The terms found in the certificate(s) include:

1. the benefit plan provisions;
2. the eligibility and effective date of insurance rules;
3. the termination of insurance rules; and
4. exclusions.

Section 4 – Premium Provisions

Premium Payments

The policyholder must pay all premiums in advance at our Home Office or to one of our agents in accordance with the policy application, which is incorporated as the signature page of this policy upon acceptance and issuance of this policy by USAble Life. The policyholder may request on any policy anniversary that the frequency of premium payment be changed to any frequency we offer for such policy.

Calculation of Premiums

The first premium is due on the policy effective date. Payment of that premium shall constitute acceptance of the policy. Future premiums are due on each premium due date. The premium is based on the premium rate and the amount of insurance in effect for the month reported on the premium due date. We will furnish premium rates to the policyholder with an explanation of how to apply them.

Our Right to Change Premium Rates

We may change the premium rate:

1. after the first renewal date;
2. at the end of any rate guarantee period; or
3. when our liability changes.

Payment of the changed premium rate shall constitute acceptance of that change.

Unless our liability changes:

1. we will not change the rates more than once in any period of 12 consecutive months; and
2. we will give the policyholder 31 days advance written notice of an increase in rates.

Section 5 – Policy Provisions

Entire Contract

The contract between the parties consists of:

1. the policy, any amendments and addenda; and
2. the application of the policyholder, a copy of which is attached to and made a part of the policy when issued, as may be amended during the term of this policy; and
3. the certificates, and the endorsements or riders which are attached to and made a part of the policy when issued; as may be amended during the term of this policy; and
4. the enrollment forms, if any, of each covered person.

All statements made by the policyholder and persons insured under the policy will be deemed representations and not warranties. No statement will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his authorized representative.

Incontestability

Except for non-payment of premium, the insurance provided to each covered person by the policy cannot be contested after a period of two (2) years from the effective date of each covered person.

Changes to the Policy

The policyholder owns the policy. We may change any or all of the provisions of this policy by notifying the policyholder. We must give the policyholder at least 31 days advance written notice of any change, unless the policyholder accepts an amendment during that period. The policy may also be changed in whole or in part when there is any change in laws or regulations which affect our obligations under the policy. A change must be approved by one of our executive officers. No agent can change the policy or waive any of its provisions. Payment of the applicable premium following any change of this policy in accordance with this section shall constitute acceptance of that change.

Grace Period

We will allow the policyholder a 31 day grace period for the payment of all premiums after the first. During this 31 day period, the policy will stay in force. If the owed premium is not paid by day 31, the policy will automatically terminate retroactive to the last day that the applicable premiums had been paid. If the policyholder gives us written advance notice of an earlier cancellation date, the policy will terminate on the earlier date.

Termination of Policy

<u>For Cause</u>

1. We may terminate this policy if we do not receive any premium when due in accordance with the Grace Period provision of the policy.
2. Either party may terminate this policy upon 30 days advance written notice, if the other party breaches its obligations and fails to cure that breach to the other party's reasonable satisfaction within that 30 day notice period.
3. Either party may terminate this policy, with or without prior notice, effective as of midnight prior to the date that the other party:
   a. ceases doing business as a going concern;
   b. makes an assignment for the benefit of creditors;
   c. admits in writing that it is unable to pay debts as they come due; or
   d. consents to the appointment of a trustee or receiver; or if a trustee or receiver is appointed pursuant to applicable Federal or State bankruptcy, insolvency or similar laws.

4. We may terminate this policy, upon not less than 30 days written notice if the employer fails to comply with a material plan provision relating to the employer's premium contribution or group participation rules or if we determine there has been a material change affecting the risk assumed under this policy.
5. Upon written notice, we may terminate or rescind the policy or the coverage on a covered person for fraud or misrepresentation by the employer or a covered person of material fact concerning the employer or covered person.

Because of Inability to Perform Obligations

The policy may be immediately suspended or terminated by written notice to the other party if either party is unable to perform its obligations for reasons beyond its control, including:

1. complete or partial destruction of facilities or equipment;
2. lockout, strike, riot, war, act of God, or any ordinance, law, order or decree of any governmental authority.

Neither party will be required to perform its duties nor be liable for any damages arising from the suspension or termination of this policy pursuant to this provision.

Certificate

We will give the policyholder an individual certificate for distribution to each covered employee. The certificate is part of the policy, and will explain the important features of the policy.

Data to Be Furnished

The policyholder will give us all information we need regarding matters pertaining to the insurance. At any reasonable time while the policy is in force and for one year after that, we may inspect any of the policyholder's documents, books, or records which may affect the insurance or premiums of this policy.

If the policyholder gives us any incorrect information, the relevant facts will be reviewed to establish if insurance is in effect and in what amount.

No person will be deprived of insurance to which he is otherwise entitled or have insurance to which he is not entitled, because of any misstatement of fact by the policyholder or covered individual. Any required adjustment may be made in coverage, premiums or benefits. However, payment of premium by or on behalf of an ineligible person will not entitle that person to coverage.

No Replacement for Workers' Compensation

The policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Time Period

All periods begin and end at 12:01 a.m., standard time, at the policyholders address.

Jurisdiction

The laws of the state where it is delivered govern this policy.

Section 6 – Self-Administered Provisions

The Parties to this provision are USAble Life and the policyholder.

Statement of Work

As a Self-Administered Group with respect to this policy, it is the responsibility of the policyholder to properly enroll its eligible employees for insurance coverage; to accurately collect premium for each employee's coverage; to remit that premium to us, and to maintain all documentation necessary for the administration of the coverages shown on the Schedule of Insurance.

The Policyholder's Obligation

The policyholder agrees to perform, while this policy is in force, the following functions:

1. verify eligibility, as defined under the policy;
2. obtain enrollment documentation for its eligible employees on forms approved and acceptable to us, such documentation to contain sufficient information to establish proof of coverage;
3. forward all enrollment documentation for coverage that requires underwriting approval to us immediately upon receipt and inform employees that coverage is not effective until approved in writing by us;
4. maintain enrollment documentation containing proof of coverage and beneficiary designations and changes thereto;
5. provide us on an annual basis, or as requested, and no less than 90 days prior to the Anniversary Date of the policy a census of all covered persons including the following data:
    a. Full name;
    b. Date of birth;
    c. Gender;
    d. Salary, if coverage is based on salary;
    e. Class or coverage amount by type of coverage;
    f. Occupation, if coverage based on occupation class or for Short Term Disability coverage;
6. remit timely payment of premiums in accordance with the policy's premium provisions;
7. enforce all policy provisions including, but not limited to, guaranteed issue (GI) amount of coverage, if applicable; late enrollee requirements; Eligibility and Effective Date provisions; limits of coverage, and changes in coverage;
8. deliver certificates of insurance to each eligible employee within 30 days of the covered person's effective date of coverage. We reserve the right to review and modify, if necessary, any and all materials pertaining to the benefits provided by us, to ensure accuracy and compliance with the policy, the certificate of insurance, and any applicable federal or state law.

Terms

1. As a Self-Administered Group, the policyholder will cooperate in audits performed by us and will provide all documentation required within the requested time frame. Such audits not to occur more frequently than once per 12-month period.
2. As a Self-Administered Group, the policyholder shall be responsible for proper deductions and administration of payroll functions for benefits that are funded partially or wholly by employees. Failure to deduct the proper amount, the calculation of which is determined by the Premium provisions of the policy, and duties listed in this Section of the policy will in no way increase our liability. We do not retain or exercise the right to direct, control or supervise the policyholder as to the policyholder's procedures for premium collection and reporting.
3. As a Self-Administered Group, the policyholder agrees to make an equitable adjustment of premiums, upon our approval, based on either or both of the following factors:
   a. the amount of premium due based on the covered person's coverage;
   b. the difference between the premium paid and the premium which would have been paid if the covered person's coverage had been correctly stated.
4. As a Self-Administered Group, the policyholder is responsible for compliance with applicable federal and state laws and specifically assumes exclusive responsibility for collection of premiums and the reporting of accurate premiums to us.
5. Enrollment periods and the period of time for any enrollment must be approved in writing by us. Enrollment documentation submitted after such approved enrollment period will require Evidence of Insurability (EOI) on a form acceptable to us, and coverage will not be effective until approved in writing by our Underwriting Department.

Underwriting Approval

The policyholder may not alter, amend or expand the underwriting approval limits specified in the policy or certificate of insurance. All individual applications that require underwriting approval, as identified in item 3 of The Policyholder's Obligations provision above, must receive our written approval before coverage shall become effective.

Records

All enrollments, beneficiary and premium records, and supplies kept by the policyholder relating to this Section of the policy shall be opened for inspection/audit by us or our representative at all reasonable times during the continuance of this policy. All such records and supplies shall be retained until authorization for their destruction is obtained from us.

Assignment

The obligations of the policyholder set out in this Section shall not be assignable, nor may any of its functions or duties be delegated without our prior written consent.

Termination

Either party may terminate self-administration of the policy by providing 30 days written notice to the other party. Notice shall be sent by certified mail and shall be effective upon receipt. The provisions of this Section shall terminate at the end of the month following the expiration of the 30 days.

Notice

Notice required to be given to us under this Section shall be sent to our address Attention: Corporate Document Manager. Notice required to be given under this Section to the policyholder shall be sent to the address shown in our records.

Hold Harmless and Indemnification

As a Self Administered Group, the policyholder shall indemnify and hold harmless USAble Life, its parents, affiliates, officers, directors, agents, successors, assigns and employees against any and all claims, demands and expenses of all kinds made against or incurred by us, resulting from or arising out of any act, negligence or misconduct of the policyholder or any agent, employee or representative of the policyholder in connection with the policyholder's duties hereunder.

Confidentiality

The Financial Services Modernization Act (Gramm-Leach-Bliley Act), hereinafter “GLB” requires that all parties that perform services on behalf of the Insurer and receive nonpublic personal, financial or health information, with respect to any applicant or insured of the Insurer, for use or disclosure during the service performance, are prohibited from disclosing or using such information for any reason other than to carry out the business purposes for which the information was disclosed.

Relationship of the Parties

In regards to this Section of the policy, the relationship between the parties shall be that of independent contractors. The parties further acknowledge that the policyholder is not our agent and shall not hold itself out as such and that the policyholder acts solely on behalf of its employees in the performance of its obligations under this Section of the policy.

USAble Life

[320 W. Capitol] • P.O. Box 1650 • Little Rock, AR 72203-1650
[(501) 375-7200 • (800) 648-0271]

CERTIFICATE OF INSURANCE

Group Term Life and Accidental Death & Dismemberment

Policyholder: SIMMONS FIRST NATIONAL BANK

Class: 001 - SENIOR VICE PRESIDENTS AND ABOVE

State of Residence: ARKANSAS

This is to certify that USAble Life has issued and delivered the Group Term Life and Accidental Death & Dismemberment Insurance Policy to the Policyholder.

The policy insures the employees and their dependents, if elected, of the policyholder who:

1. are eligible for the insurance;
2. become insured; and
3. continue to be insured;

according to the terms of the policy.

The terms of the policy that affect your insurance are contained in the following pages.

This Certificate of Insurance is a part of the policy. This certificate replaces any other that USAble Life may have issued to the policyholder to give to you under the Group Insurance Policy specified herein.

Signed for USAble Life:

James L. Tourse — Secretary

Jason Ham — President

Table of Contents

Schedule of Insurance

Policyholder:	SIMMONS FIRST NATIONAL BANK
Group Policy Number:	50001328
Policy Effective Date:	September 1, 2010* *This certificate replaces any certificate issued before the date shown.
Eligible Class:	Class 001 - SENIOR VICE PRESIDENTS AND ABOVE
Full-time Employment:	30 hours weekly
Renewal Date:	September 1, 2012

Waiting Period: You will be eligible for coverage on the first of the policy month following completion of the following period of continuous active work:

1. If you are working for the employer on the policy effective date – 0 days
2. If you start working for the employer after the policy effective date – 30 days

Benefits amounts for eligible employees shall be determined in accordance with the following schedule:

Benefit	Benefit Amount
Employee Basic Life	2.0 Times Annual Salary rounded to the next higher $1,000, if not exact, to a maximum of $500,000.
Employee Basic Accidental Death & Dismemberment	2.0 Times Annual Salary rounded to the next higher $1,000, if not exact, to a maximum of $500,000.
Group Life Accelerated Benefits	75% up to $250,000
AD&D Coma Rider	5% per month for 11 months
AD&D Exposure & Disappearance Rider	AD&D benefit payable after 1 year of accidental disappearance
AD&D Repatriation Rider	10% up to $5,000
AD&D Seat Belt & Air Bag Rider	Seat Belt: 10% up to $10,000 Air Bag: 10% up to $10,000

If a covered person is eligible for any amount in excess of the guaranteed issue amount shown below, the employee must furnish evidence of insurability, which is subject to our approval.

Benefit	Guaranteed Issue Amount
Employee Basic Life	The lesser of 2.0 Times Annual Salary rounded to the next higher $1,000, if not exact, or $300,000.
Employee Basic Accidental Death & Dismemberment	The lesser of 2.0 Times Annual Salary rounded to the next higher $1,000, if not exact, or $300,000.

Reductions, Terminations, and Special Provisions

Employee Basic Life	For all employees who retire under the employer's retirement plan before age 70, benefits will reduce to $5,000 upon retirement. Benefits will terminate at age 70. For all other employees who are not eligible for the employer's retirement plan, benefits will reduce to 66 2/3% at age 65 and to 33 1/3% at age 70. Terminates at retirement.
Employee Basic Accidental Death & Dismemberment	Reduces to 66 2/3% at age 65 and to 33 1/3% at age 70. Terminates at retirement.

Definitions

The terms listed, if used, will have these meanings.

Accident or Injury mean accidental bodily injury sustained by the covered person while insured under the policy which is the direct cause of the loss, independent of disease or bodily infirmity or any other cause.

Active Work or Actively at Work mean the expenditure of time and energy for the policyholder or an associated company at your usual place of business on a full-time basis. If you are not working on a day your coverage would otherwise take effect, you will be considered to be at active work on that day only if:

1. when that work day begins, it would be reasonable to expect that you would be physically and mentally able to complete a full-time week of work in your regular occupation; and
2. you are not disabled; and
3. your contract of employment, if applicable, remains active; and
4. you are not on an unapproved, administrative or disciplinary leave; and
5. you return to work at the end of a paid break or vacation period.

Annual Salary means your annual base rate of pay, excluding any overtime pay, bonuses, or other extra pay. If your pay is from commissions, your annual salary will be based on your average commissions for the prior 12 months.

Associated Company means any company shown in the application which is owned by or affiliated with the policyholder.

Beneficiary means the person or entity you choose to receive your amount of insurance at your death.

Contributory means you pay part of the premium.

Covered Person means an eligible employee or the employee's dependents whose insurance has become and remains effective under all the conditions and provisions of the policy. Covered persons do not include contract, temporary, seasonal, or part-time workers.

Eligible Class means a class of persons eligible for insurance under the policy. This class is based on employment or membership in a group.

Eligible Persons means a person who:

1. is a citizen of the United States of America (U.S.) or Canada, who either:
   a. resides in the U.S. or Canada; or
   b. is stationed outside the U.S. or Canada for a period of less than 6 months; or
2. is a foreign national residing in the U.S. and meets all of the following requirements:
   a. has a valid permanent residency visa;
   b. participates in U.S. Social Security; and
   c. is covered by Workers' Compensation.

Employee means an eligible person who is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the policyholder or an associated company; or
4. a retiree, if listed as eligible in the policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the above conditions.

Employer means the policyholder.

Evidence of Insurability means a signed health and medical history form provided by us, a medical examination, if requested, and any additional information and attending physicians' statements that we may require.

Family Member means a person who is a parent, spouse, child, sibling, domestic partner, grandparent, grandchild, step-child, step-parent, step-sister, step-brother, father-in-law, or mother-in-law of the covered person; or spouses, as applicable, of any of these.

Full-time means working at least the number of hours indicated in the Schedule of Insurance for Full-time employment.

Gender – The use of the male pronoun also includes the female.

Home Office means the principal office of USAble Life in Little Rock, Arkansas.

Hospital means a facility supervised by one or more physicians and operated under state and local laws. It must have 24-hour nursing service by registered graduate nurses. It may specialize in treating alcoholism, drug addiction, chemical dependency, or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged.

Hospital Confined and Hospital Confinement mean staying in a hospital as a registered inpatient for 24 hours a day.

Material Duty or Material Duties mean the sets of tasks or skills required generally by employers from those engaged in an occupation. We will consider one material duty of your regular occupation to be the ability to work for an employer on a full-time basis as defined in the policy.

Noncontributory means the policyholder pays the premium.

Occupation means a group of jobs:

1. in which a common set of tasks is performed; or
2. which are related in terms of similar objectives and methodologies, and which may be related in terms of materials, products, worker actions, or worker characteristics.

Physician means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. This includes a person whom we are required to recognize as a physician by the laws or regulations of the governing jurisdiction. However, neither you nor a family member will be considered a physician.

Plan means the policy and certificates of insurance provided for covered persons.

Plan Administrator means the employer that sponsors the plan for the benefit of its employees and eligible dependents.

Policy means the group policy issued by us to the policyholder that describes the benefits for which you may be eligible.

Policyholder means the entity to which the policy is issued.

Regular Care means you personally visit a physician as often as is medically required to effectively manage and treat your disabling condition(s), according to generally accepted medical standards; and you are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the sickness or injury causing your disability must be given by a physician whose specialty or experience is appropriate.

Regular Occupation means the occupation in which you were working immediately prior to becoming disabled.

Retiree or Retirement means you begin receiving retirement benefits from either:

1. a retirement plan sponsored by your employer, the policyholder, or an associated company, or
2. a government plan.

Sickness means a disease or illness, including pregnancy.

United States of America means the fifty (50) states of the United States and the District of Columbia. It does not include territories of the United States.

Waiting Period is the number of continuous days of service during which you must be an active, full-time employee in a class eligible for insurance before you become eligible for coverage.

We, Us, and Our mean USAble Life.

You and Your mean an employee of the policyholder or an associated company who has met all the eligibility requirements for coverage, and is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the employer, or associated company covered under the policy; or
4. a retiree, if listed as eligible in the group Policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the conditions listed above.

Eligibility and Effective Date Provisions

Eligible Employee

If you are working on a full-time basis for the employer, you are eligible for insurance after completion of the required waiting period, provided you are in a class of employees who are included.

Employee Eligibility Date

If you are working for your employer in an eligible class, the date you are eligible for coverage is the latest of the following dates:

1. the policy effective date;
2. the day after you complete any waiting period shown in the Schedule of Insurance by continuous service with the employer, the policyholder, or an associated company;
3. the date the policy is changed to include your class; or
4. the date you become a member of a class eligible for insurance.

Rehires: If you were insured under this policy and your insurance terminated due to termination of employment or eligibility, and you again become an eligible employee within 12 months, there is no waiting period.

Effective Date of Employee Insurance

You must use forms approved by us when applying for insurance.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When your Employer pays 100% of the cost of your coverage under the policy, you will be covered at 12:01 a.m. at your employer's address on your eligibility date.
2. When you and your Employer share the cost of your coverage under the policy or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. at your employer's address on the latest of the following dates:
   a. on your eligibility date, if you enroll for insurance within 31 days after the date you first become eligible for coverage; or
   b. on the first day of the policy month following the date we approve your application if you do not apply for insurance within 31 days after your eligibility date.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, your coverage will be effective on the first day of the policy month following the date we approve your application.

Delayed Effective Date

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, it will take effect on the day you return to active work. If your insurance is scheduled to take effect on a non-working day, your active work status will be based on the last working day before the scheduled effective date of your insurance.

Changes in Coverage Provisions

When Coverage Amounts Change (Redetermination Date)

The policy redetermines your amount of insurance on the first of the policy month after a change occurs. If benefits are based on your salary, the policyholder must report updates to all covered person's earnings as they occur. Changes to a covered person's earnings are subject to any proof of insurability requirements of the policy. As of the policy's redetermination date, we use a covered person's salary or earnings on record with us to: (a) set rates; (b) set benefit amounts and limits; and (c) calculate premium payable under the policy.

Delayed Effective Date of Change

You must be actively at work on a full-time basis on the redetermination date. If you are not, your coverage amount will not change until the date you return to active work on a full-time basis. Changes in salary or earnings will not apply to a recurring disability.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

Changes to the Policy

Any increase or decrease in coverage because of a change in the plan of insurance will become effective on the date of the change. The Delayed Effective Date provision will apply to an increase.

Termination Provisions

Termination of Employee Insurance

Your insurance will terminate at 12:00 midnight on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date the policy terminates, or the date a specified benefit terminates;
3. the date you cease to be a member of a class eligible for insurance;
4. the date you cease to be actively at work;
5. if your coverage is continued under the Waiver of Premium provision, the date specified under "Termination of the Extended Insurance Benefit."

Continuation of Insurance

If you are unable to perform active work for a reason shown below, the policyholder may continue your insurance, except for any Accidental Death and Dismemberment coverage, on a premium-paying basis provided you remain in other respects a member of an eligible class. The continuance cannot be more than the maximum continuance shown below. The employer must act so as not to discriminate unfairly among employees in similar situations.

The maximum continuance for insurance is the longest applicable period described below:

1. six months following the date active work stopped due to lay-off or approved leave of absence, or
2. twelve months following the date active work stopped due to your total disability.

Total Disability for Continuation of Insurance means that you are under the regular care of a physician, and prevented by injury or sickness from performing all of the material duties of your regular occupation.

Claim Provisions

Notice of Loss

Written notice of claim must be given to us at our Home Office within 30 days after a loss occurs or begins, or as soon after the loss as is reasonably possible to do so, but not later than one (1) year from the time notice is required. The notice should identify the covered person and the nature of the loss.

Within 15 days after the date of your notice, we will send you claim forms. The forms must be completed and sent to our Home Office. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.

Proof of Loss

For any loss for which the policy provides periodic payment contingent upon continuing loss, written proof of loss must be given to us within 90 days after the termination of the period for which we are liable. For any other loss covered by the policy, written proof of loss must be given to us within 90 days after the date of such loss. Failure to furnish proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time. Such proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof was otherwise required.

Physical Examination and Autopsy

We have the right to have a physician of our choice examine the covered person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.

Payment of Claims

All benefits payable under this policy will be payable immediately upon receipt of due written proof of such loss.

If included, Dismemberment benefits will be paid to you. Employee Life insurance and Accidental Death benefits will be paid to the person(s) named by you to receive them.

If you failed to name a beneficiary or if no named beneficiary is living at your death, refer to the "Beneficiary" provision below. At our option, up to the maximum allowable by the state laws of the covered person's state of residence may be paid to any person who incurred funeral or other expenses related to the last illness or death of the covered person.

Beneficiary

Your beneficiary will be the person(s) you name in writing to receive any amount of insurance payable due to your death. The beneficiary's name is on record in our Home Office, or in the policyholder's office if the group is self-administered.

You may name or change a beneficiary by giving us written notice at our Home Office (or by giving the policyholder written notice if the group is self-administered) on a form acceptable to us. When we receive the notice, it will be effective on the date made, subject to any payment we may have made before we receive it.

If there is no named beneficiary living at your death, we may pay, at our discretion, any amount due to one of the following classes of survivors: (1) your spouse; (2) your surviving children in equal shares; (3) your mother and/or father; (4) your brother and/or sister; or (5) your estate.

Assignment

You may transfer your rights to name or change the beneficiary to someone else by assignment. An assignment will affect us only if it is in writing on a form acceptable to us, and is received at our Home Office. When we record it, the assignment will take effect as of the date you made it. The assignment will be subject to any action we may have taken before we record it. We take no responsibility for the validity of any assignment.

Claims of Creditors**:** To the extent allowed by law, proceeds will not be subject to any claims of a beneficiary's creditors.

Authority

The policyholder delegates to us and agrees that we have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the policy.

We decide: (a) if a covered person is eligible for this insurance; (b) if a covered person meets the requirements for benefits to be paid; and (c) what benefits are to be paid by the policy. We also interpret how the policy is to be administered. What we pay and the terms for payment are explained in this certificate.

Limit on Legal Action

No action at law or in equity may be brought against the policy until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations has expired, but, in any case, not after three (3) years from the date of loss.

Review Procedure

You must request, in writing, a review of a denial of your claim within 180 days after you receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit written comments, documents, records and other information relating to your claim for benefits.

We will review your claim after receiving your request and send you a notice of our decision within 45 days after we receive your request, or within 90 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant provisions of the policy. We will also advise you of your further appeal rights, if any.

Subrogation and Right of Reimbursement

The plan assumes and is subrogated to your legal rights to recover any payments the plan makes for benefits, when a covered sickness or injury resulted from the action or fault of a third party. The plan's subrogation rights include the right to recover the amount of benefits paid to you.

The plan has the right to recover any and all amounts equal to the plan's payments from:

1. the insurance of the injured party;
2. the person, company (or combination thereof) that caused the sickness or injury, or any insurance company; or
3. any other source, including disability benefit coverage.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The plan's recovery will not be reduced by your negligence, nor by attorney fees and costs you incur.

Priority Right of Reimbursement

Separate and apart from the plan's right of subrogation, the plan shall have first lien and right to reimbursement. This priority right of reimbursement supersedes your right to be made whole from any recovery, whether full or partial. You agree to reimburse the plan 100% first for any and all benefits provided through the plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

1. any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from your own insurance and/or from the third party (or their insurance);
2. any auto or recreational vehicle insurance coverage or benefits including, but not limited to disability benefit coverage; and
3. business and homeowner disability insurance coverage or payments.

The plan may notify those parties of its lien and right to reimbursement without notice to or consent from any covered person.

This priority right of reimbursement will not be reduced by attorney fees and costs you incur.

The plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available disability insurance coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

Notice and Cooperation

You are required to notify us promptly if you are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable us to protect the plan's rights under this section. You are also required to cooperate with us and to execute any documents that we, acting on behalf of the policyholder, deems necessary to protect the plan's rights under this section.

You shall not do anything to hinder, delay, impede or jeopardize the plan's subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the plan to withhold any and all benefits due you under the plan. This is in addition to any and all other rights that the plan has pursuant to the provisions of the plan's subrogation rights and/or priority right of reimbursement.

If the plan has to file suit, or otherwise litigate to enforce its subrogation rights and/or priority right of reimbursement, you are responsible for paying any and all costs, including attorneys' fees, the plan incurs in addition to the amounts recovered through the subrogation rights and/or priority right of reimbursement.

Legal Action and Costs

If a covered person settles any claim or action against any third party, that covered person shall be deemed to have been made whole by the settlement and the plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. The covered person shall hold any such proceeds of settlement or judgment in trust for the benefit of the plan. The plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the covered person in such circumstances.

Additionally, the plan has the right to sue on the covered person's behalf, against any person or entity considered responsible for any condition resulting in benefits paid or to be paid by the plan.

Settlement or Other Compromise

The covered person must notify the plan prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the plan's rights so that the plan may be present and protect its subrogation rights and/or priority right of reimbursement.

The plan's subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against the covered person.

The right of subrogation and the right of reimbursement are based on the plan language in effect at the time of judgment, payment, or settlement.

The plan, or its representative, may enforce the subrogation and priority right of reimbursement.

Alternate Dispute Resolution Procedures

This dispute resolution procedure ("procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all disputes with us. Such disputes include any matters that cause you to be dissatisfied with any aspect of your relationship with us, including any claim, controversy, or potential cause of action you may have against us. Please contact the Dispute Resolution office at (800) 648-0271 if you have any questions about this section of the certificate or to begin the dispute resolution process.

The following terms are applicable to all disputes:

1. This procedure is the exclusive method of resolving any disputes.
2. The procedure can only resolve disputes that are subject to our control.
3. This procedure will be governed by the Employee Retirement Income Security Act of 1974 ("ERISA"); Rules and Regulations for Administration and Enforcement; Claims Procedure (the "Claims Regulation"). That includes the definition of an adverse benefit determination, which is defined as any denial, reduction, termination or failure to provide or make payment for what you believe should be a covered benefit.
4. You may request a form from our Dispute Resolution office to authorize another person to act on your behalf concerning a dispute.
5. We may elect to skip one or more of the steps of this procedure if it is determined that step will not help to resolve the dispute.
6. Any dispute will be resolved in accordance with the terms of this certificate, applicable state or Federal laws and regulations.
7. You must begin the dispute process within 180 days from the date you receive notice of an adverse benefit determination. If you do not initiate the dispute process within that 180 day period, you give up the right to take any action based on that Dispute.

Description of the Procedure

Inquiry

You should contact our Dispute Resolution office to discuss and attempt to resolve any issues regarding a dispute. We hope that this informal process will resolve your questions or concerns.

Appeals

If you are not satisfied with the response to your inquiry, you may submit a written request (an "appeal") to the Office of the Appeals Coordinator, USAble Life, P.O. Box 1650, Little Rock, AR 72203-1650, asking that we reconsider an adverse benefit determination. Please contact the Dispute Resolution office if you have any questions about how to submit an appeal to us. You are not required to use a specific form, but you may request that the Dispute Resolution office send you a blank appeal form to ensure that you provide the information that will be needed to review your appeal.

We will assign a coordinator to review your appeal. The appeal coordinator is an individual with appropriate expertise who is neither the individual who made the adverse benefit determination, nor a subordinate of that individual.

The appeal coordinator may request that you submit additional information concerning your grievance. The appeal coordinator will also consider information submitted by others, including information requested from other USAble Life representatives. The appeal coordinator will have full discretionary authority to make eligibility, benefit or claim determinations and construe the terms of the policy. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the policy is not governed by ERISA.

We will make a decision within 60 days after receiving your appeal concerning a claim determination.

The appeal coordinator will send you a written decision concerning your appeal. The appeal coordinator's decision will include: a statement of the coordinator's understanding of your appeal; a statement explaining the basis of the decision; and a list of the documents or information upon which that decision was based. We will send you a copy of the listed documents, without charge, if you make a written request for such documents.

Post Appeal Procedure

If you are still not satisfied after completing the appeal procedure, you have the right to bring a civil action against us to obtain the remedies available pursuant to Sec. 502(a) of ERISA (an "ERISA Action") after completing the mandatory appeal process. Those ERISA remedies will apply to this policy even if your plan is not otherwise governed by ERISA. If you agree to arbitrate a dispute, we agree to suspend (or toll) any time periods affecting your right to bring an ERISA Action against us related to that dispute, until the arbitration has been completed.

You may request that the dispute be submitted for resolution by arbitration. That arbitration request must be submitted, in writing, to USAble Life's General Counsel within sixty (60) days after you receive the appeal coordinator's decision.

The dispute will be submitted to arbitration in accordance with the rules of the American Arbitration Association, unless we both agree to use an alternative dispute resolution administrator or procedure. The arbitration will be conducted before a single arbitrator.

We will pay the filing fee charged by the administrator and the arbitrator. You will be solely responsible for any other costs that you incur to participate in the arbitration process, including your attorney's fees. The filing fee and arbitrator's fees may be reallocated as part of an arbitration award, in whole or in part, at the discretion of the arbitrator.

The arbitration will be conducted in a location where it is reasonably convenient for you to participate. If we cannot agree concerning a convenient location, the administrator or arbitrator, if appointed, shall have the discretion to decide where the arbitration will be conducted.

The arbitrator: (a) shall consider the dispute individually and shall not certify or consider multiple disputes as part of a class action; (b) shall be required to issue a reasoned written decision explaining the basis of his or her decision and the manner of calculating any award; (c) shall limit his or her decision to deciding if our adverse benefit decision was arbitrary or capricious based on ERISA standards; (d) may not award punitive, extra-contractual, treble or exemplary damages unless permitted to do so by applicable statutes or regulations; (e) may not vary or disregard the terms of the policy; and (f) shall be bound by controlling law; when issuing a decision concerning the dispute.

The arbitrator shall limit discovery to the extent possible consistent with the objective of completing the arbitration in a fair, prompt, and cost effective manner. Emergency relief such as injunctive relief may be awarded by the arbitrator.

Contact Information

General Counsel
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: [(800) 648-0271]
Email: AppealCoordinator@usablelife.com

Office of the Dispute Resolution Coordinator
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
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General Provisions

Entire Contract

This certificate is furnished in accordance with and subject to the terms of the policy. The entire contract consists of the policy, which includes the application, any amendments and addenda; this certificate; your enrollment form, if required; and any riders or endorsements. No change in the policy will be effective until approved by one of our officers. This approval can only be in writing and must be noted on or attached to the policy. No agent has authority to change the policy or certificate or to waive any of their provisions.

Any statement made by you or the policyholder is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about you or the policyholder's plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

Incontestability

Unless the premiums have not been paid, the validity of the policy cannot be contested after it has been in force for two years.

Any statement made by the policyholder or a covered person will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the covered person or the beneficiary.

No statement, except fraudulent misstatement, made by a covered person about insurability will be used to deny a claim for a loss incurred or disability starting after coverage has been in effect for two years.

No claim for loss starting two or more years after the covered person's effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Agency

Neither the policyholder, any employer, any associated company, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

Unpaid Premium

We may deduct any unpaid premium then due from the payment of a claim under this certificate.

Refund of Premium

On the death of the covered person, proceeds payable hereunder shall include the amount of unearned premium paid beyond the end of the policy month in which death occurred. Payment shall be made in one lump sum no later than 30 days after proof of the covered person's death has been furnished to us.

Conformity with State Statutes

If the provisions of this certificate do not conform with the laws of the state in which you reside on the certificate effective date, they are hereby amended to conform with the minimum requirements of the statutes of that state.

Policy Management

Efficient management of the policy requires the joint efforts of the policyholder, USAble Life, and each covered person. Each party has certain duties to bring about the effective administration of the policy.

Duties of the Policyholder: The policyholder's primary duties under the policy are listed below.

1. Give us prompt, written notice of any change in business of the policyholder and employer. This includes, but is not limited to: (a) the type of business; (b) addition or deletion of an associated company; or (c) financial status due to bankruptcy; merger; acquisition; or dissolution.
2. Give us pertinent records for all covered persons. This includes, but is not limited to: (a) hire dates; (b) eligibility dates; (c) salaries; (d) occupations; and (e) birth dates. Give us updates of such records as needed.
3. Give us prompt notice of a covered person's disability. This notice should be given as soon as possible after the date of injury or start of sickness. The most effective time for such notice is when the covered person has not been able to perform active work for 30 days.
4. Give us occupational data for all disabled covered persons. This includes, but is not limited to: (a) job descriptions and analyses; and (b) environmental factors.

Duties of Covered Persons and Beneficiaries: Your and your beneficiary's primary duties under the policy are listed below:

1. Give notice and proof of loss as soon as possible after the date of your injury or sickness, or the date of your death, or the death of a covered dependent, if applicable.
2. Give a complete account of the details of your injury or sickness or the death on a form approved by us.
3. Provide any other official documents to review the loss such as a certified death certificate, investigating officer's report, or medical records.
4. Allow release of medical and income data needed to adjudicate your claim.
5. Provide evidence of the regular care of a physician, if necessary.
6. Promptly report to us any changes in your status such as your address or telephone number, or if you return to work or are no longer disabled.
7. If benefits are overpaid, reimburse such overpayment within 60 days of the date benefits were overpaid.
8. Provide proof of your earnings for the period prior to a loss.

Fraud

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the policy and recovery of any amounts we have paid.

Employee Term Life Insurance

Death Benefit

We will pay your beneficiary the amount of insurance in force on the date of death, as shown in the Schedule of Insurance, when we receive all required proof of loss, including written proof of your death acceptable to us and a completed claim form.

Conversion Privilege for Life Insurance

Conversion upon Termination of Employment or Eligibility

For Employees
You may convert all or part of your life insurance to an individual policy of life insurance, other than Term,

1. if all or part of it stops for any reason; unless
2. it stops because you did not pay any required premiums.

The amount you may apply for may not be more than:

1. the life amount then in force; or
2. that part of the life amount which has stopped, whichever is less.

Accidental death and dismemberment, disability or any other supplemental coverage for which you are eligible under this policy may not be converted.

Conversion upon Termination or Amendment of Group Policy

Any covered person may convert a limited amount of life insurance if he has been continuously insured under the policy for at least five (5) years and his insurance ends due to termination or amendment of the policy.

The amount you may convert in this case is the smaller of the following:

1. the amount of life insurance which terminates, less the amount you became eligible for under any group policy within 31 days after this insurance terminated; or
2. $10,000.

Conversion Coverage

Any covered person may convert his life insurance to any policy we are issuing for the purpose of conversions other than Term. The conversion policy will not have disability or other supplementary benefits. No evidence of insurability will be required. The premium will be based on the amount and the form of the conversion policy, and on the covered person's class of risk and age on the date the conversion takes effect.

A conversion policy is in lieu of all other benefits under this policy. If you qualify for the Extended Insurance Benefit, any conversion policy issued will be canceled. Premiums paid for the converted policy will be returned.

The conversion policy will take effect on the 32nd day after the insurance terminates.

Notice and Application Required

Written application and the first premium payment for the conversion policy must be received in our Home Office within 31 days after the covered person's insurance terminates. If you are not given notice of the right to convert by the 16th day of the 31 day conversion period, you will have an additional period in which to apply for conversion. The additional period will end 15 days after you are given notice, but not more than 61 days after the date the insurance under the policy ended.

Nothing in the policy will continue coverage for more than 31 days following the date coverage ends under the policy. Written notice, contained in this certificate of insurance and given to you at any time, or mailed by the policyholder to your last known address will be considered sufficient written notice to you. It is the responsibility of the policyholder to give such notice to you.

Conversion Period Death Benefit

If the covered person dies within the 31 days allowed for making application to convert, we will pay the amount he was entitled to convert. We will do this whether or not application was made.

Life Insurance – Waiver of Premium

This section applies to the Basic Life Insurance Benefit only.

Extended Insurance Benefit (Waiver of Premium)

We will continue the term life insurance in force without premium payment if you become totally disabled provided:

1. you are insured under this plan and are actively at work on or after the effective date of the plan; and
2. your total disability begins before age 70; and
3. you provide us with proof of total disability as required; and
4. you are still totally disabled when you submit the proof of disability.

Amount of Life Insurance

The amount of life insurance continued will be the amount in force on the date you became totally disabled. This amount will be reduced or terminated based on the Schedule of Insurance in effect on the date of total disability. This amount will not be increased while you remain totally disabled.

Definition of Total Disability

For the purposes of waiver of premium, "total disability" or "totally disabled" means that you are under the regular care of a physician, and prevented by injury or physical or mental sickness from performing the material duties of any gainful occupation.

Gainful Occupation means any employment that exists in the national economy that you may be expected to follow based on your education, training, experience, age, and physical and mental capacity, and from which you are expected to earn at least 80% of your pre-disability earnings within 12 months of your return to active work.

Proof of Total Disability

Upon receipt of Notice of Loss, we will provide forms which you must use when giving us proof of total disability. (See "Notice of Loss" under the Claim Provisions.) You must give us proof no later than 12 months after the date you became totally disabled. We may at any time require proof that total disability continues. You must give us proof of continuing disability within 60 days after our request. After you have been totally disabled for more than two years from the date of total disability, we will not request proof more than once a year. We may require that you be examined at our expense by a physician of our choice.

Death While Totally Disabled

If you die while your life insurance is being continued under this provision, we will pay the amount of insurance if we receive proof:

1. of your death; and
2. that total disability was continuous from the date it began to the date of death.

Termination of the Extended Insurance Benefit

You will no longer be eligible for the Extended Insurance Benefit and your life insurance will terminate on the earliest of the following dates:

1. the date you cease to be totally disabled. But, if you are still eligible for life insurance when you return to active work, your life insurance may be continued in force if premium payments are resumed. If this is done, any increased amount of life insurance you may

then be eligible for will take effect as described in the Effective Date of Insurance provision; or

2. the last day of the 60 day period following our request for proof of total disability, if you do not give us proof or you refuse to take a medical exam; or
3. the date you attain age 70.

If your life insurance terminates while you are covered under this provision, you will be eligible to convert that coverage as of the termination date. You may convert no more than the amount of term life insurance that was in force on you on that date. (See “Conversion Privilege for Life Insurance” provision.)

Accidental Death & Dismemberment Insurance

This section applies to the Basic Accidental Death & Dismemberment (AD&D) Benefit.

For Basic AD&D, you are the only covered person under this benefit.

If a covered person suffers a loss described below, we will pay the amount of insurance that applies. You or your beneficiary must give us proof that:

1. injury occurred while the insurance was in force under this section;
2. loss occurred within 365 days after the injury; and
3. loss was due to injury independent of all other causes.

Amount of Insurance

If a covered person suffers a specified loss, we will pay the benefit set opposite such loss; provided, however, that if the covered person sustains more than one such loss as the result of any one accident, we will pay only the one largest amount to which the covered person is entitled. In paying the benefit, we will consider only losses sustained while insured under this benefit.

Loss of Life .....100% of the AD&D Amount

Loss of Two or More Members.....100% of the AD&D Amount

Loss of One Member.....50% of the AD&D Amount

Loss of Thumb and Index Finger
of the Same Hand .....25% of the AD&D Amount

Member means hand, foot, sight, speech, or hearing.

Loss of sight means total and irrecoverable loss of sight.

Loss of hands or feet means total and irrecoverable loss due to severance at or above the wrist or ankle, unless the state in which the policy is issued defines the loss differently.

Loss of Thumb and Index Finger means total and irrecoverable loss at the proximal phalanx.

Loss of speech means a total and irrecoverable loss of audible communication.

Loss of hearing means permanent total deafness in both ears such that it cannot be corrected to any functional degree by any aid or device.

Exclusions

We will not pay a benefit for a loss caused directly or indirectly by:

1. disease, bodily or mental infirmity, or infection (except bacterial infection of a visible injury);
2. war or any act of war, or while serving in the armed forces of any country or international authority;
3. suicide or intentional, self-inflicted injury, whether sane or insane;
4. your active participation in a riot or insurrection;
5. your voluntary commission of, or attempting to commit, an assault or felony; or participating in an illegal occupation;
6. your voluntary use of any drug, hallucinogen, controlled substance, or narcotic unless taken as prescribed by a physician;
7. travel or flight in, or descent from, any aircraft unless as a fare paying passenger on a commercial airline flying between established airports on: (a) a scheduled route, or (b) a charter flight;

8. your being intoxicated as defined by the laws of the jurisdiction in which the accident occurred. Conviction is not necessary for a determination of being intoxicated.

Participation in a riot shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.

Riot shall include all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

War means declared or undeclared war or a conflict involving the armed forces of any country, group of countries, governments, or international organization.

Group Life Accelerated Benefit

This section applies to the Basic Life Insurance Benefit only.

Notice of Possible Tax Consequences

Please be advised that receipt of the accelerated benefits may be taxable. Any person who receives accelerated benefits should consult his personal tax advisor.

The receipt of accelerated benefit payments may adversely affect the covered person's eligibility for Medicaid or other government benefits or entitlements.

Definitions

"Terminal Illness" means a medical condition:

1. which is expected to result in the covered person's death within 12 months; and
2. from which the covered person is not expected to recover.

Eligibility

All covered employees under age 70 who are insured for a minimum of $10,000 of life insurance under the policy are eligible.

A covered employee is eligible for the accelerated benefit only if he becomes and remains insured for life insurance under the policy.

Accelerated Benefit

The accelerated benefit is an advance payment to the covered person who:

1. is terminally ill; and
2. elects to receive part of his life insurance benefit payable under the group policy, subject to the maximum benefit amounts stated on the Schedule of Insurance.

We will pay an accelerated benefit to you when we receive the following:

1. a written request for payment of the accelerated benefit; and
2. proof that the covered person is terminally ill and his illness is expected to result in his death within 12 months.

The accelerated benefit will be paid only once for each eligible covered person, and in one lump sum to you before death occurs.

Cost of Providing the Accelerated Benefit

There is no cost associated with providing the accelerated benefit.

Amount of Accelerated Benefit

The maximum accelerated benefit will be the lesser of:

1. 75% of the covered person's life insurance amount; or
2. $250,000.

If the covered person's life insurance amount is scheduled for a reduction within 12 months after the date you request the payment of the accelerated benefit, the maximum accelerated benefit will be based on the reduced amount.

Irrevocable Beneficiary

For the purpose of the Accelerated Benefit provision, an irrevocable beneficiary is a named beneficiary whose rights to the employee's life insurance proceeds are vested and whose rights cannot be cancelled by the employee unless the irrevocable beneficiary consents.

Conditions and Requirements for Payment of the Accelerated Benefit

You must request payment of an accelerated benefit in writing.

Proof that the covered person is terminally ill must be provided to us. The proof must be certified by a licensed physician and in a form that is satisfactory to us. We are not obligated to ask for any proof. Any delay in submitting proof will not cause a request to be denied if the proof is given to us as soon as reasonably possible.

After receipt of such proof, we may require the covered person to be examined by a licensed physician of our choice, at our expense. If there is a disagreement between the two physicians, we may require the covered person to be examined by another licensed physician of our choice, at our expense. The decision of the third physician will be final.

Effect of Payment of an Accelerated Benefit on Policy Provisions

The covered person's amount of life insurance under the policy will be reduced by the amount of any accelerated benefit that has been previously paid.

The following will be based on the reduced life insurance amount:

1. the amount of life insurance payable to the beneficiary when the covered person dies;
2. the amount of life insurance the covered person can convert under the policy; and
3. the premiums payable for the covered person's life insurance under the policy after an accelerated benefit is paid to you, if such premiums are not waived.

The payment of an accelerated benefit will not affect the amount of the covered person's Accidental Death and Dismemberment Benefits under the group policy, if any.

Exclusions

We will not pay an accelerated benefit if:

1. the covered person has made an absolute assignment of his life insurance under the policy and we do not receive written consent by the absolute assignee;
2. all or part of the covered person's life insurance under the group policy is to be paid to his children or former spouse as part of a court approved divorce agreement;
3. the covered person has made an irrevocable beneficiary designation of his life insurance under the policy and we do not receive written consent by the irrevocable beneficiary; or
4. the terminal illness is a result of intentional self-inflicted injury or attempted suicide, committed while sane or insane.

Date Insurance Ends under this Benefit

A covered person's insurance under this benefit will end at the earliest of:

1. the date the accelerated benefit is paid to you on the covered person's behalf;
2. the date the covered person's life insurance ends under the policy; or
3. the policy anniversary on which the covered person is age 70.

Important Notice

The following information is provided to assist you in answering any questions you might have:

Soliciting Agent
The name, address and telephone number of our soliciting agent is available to you, if needed, by calling our Customer Service Department at [(800) 370-5856].

USAble Life

USAble Life
P. O. Box 1650
Little Rock, AR 72203-1650
Toll Free [(800) 370-5856]

If we fail to provide you with reasonable and adequate service, you may contact:

Arkansas Insurance Department

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Phone (501) 371-2640 or
Toll Free 1-800-852-5494

We appreciate the opportunity to serve your insurance needs.

ERISA Information

Plan Sponsorship and Administration

The plan was established by the actions of your employer, which continues to act as Plan Sponsor and Plan Administrator. Your employer, as Plan Administrator, performs the functions of distributing Plan notices and information to employees and other Plan participants, coordinates employees' and eligible dependents' enrollment in the Plan, and transmits Plan premium payments.

ERISA Rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.
4. Neither your employer, nor any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
5. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
6. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, provided that you have first followed the Plan's designated appeals procedure before bringing suit.
7. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees.
8. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
9. If you have any questions about your Plan, you should contact the Plan Administrator.
10. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

USAble Life

[320 W. Capitol] • P.O. Box 1650 • Little Rock, AR 72203-1650
[(501) 375-7200 • (800) 648-0271]

CERTIFICATE OF INSURANCE

Group Term Life and Accidental Death & Dismemberment

Policyholder: SIMMONS FIRST NATIONAL BANK

Class: 002 – ALL FULL TIME ACTIVE EMPLOYEES

State of Residence: ARKANSAS

This is to certify that USAble Life has issued and delivered the Group Term Life and Accidental Death & Dismemberment Insurance Policy to the Policyholder.

The policy insures the employees and their dependents, if elected, of the policyholder who:

1. are eligible for the insurance;
2. become insured; and
3. continue to be insured;

according to the terms of the policy.

The terms of the policy that affect your insurance are contained in the following pages.

This Certificate of Insurance is a part of the policy. This certificate replaces any other that USAble Life may have issued to the policyholder to give to you under the Group Insurance Policy specified herein.

Signed for USAble Life:

James L. Tourse — Secretary

Jason Ham — President

Table of Contents

Schedule of Insurance

Policyholder:	SIMMONS FIRST NATIONAL BANK
Group Policy Number:	50001328
Policy Effective Date:	September 1, 2010* *This certificate replaces any certificate issued before the date shown.
Eligible Class:	Class 002 – ALL FULL TIME ACTIVE EMPLOYEES
Full-time Employment:	30 hours weekly
Renewal Date:	September 1, 2012

Waiting Period: You will be eligible for coverage on the first of the policy month following completion of the following period of continuous active work:

1. If you are working for the employer on the policy effective date – 0 days
2. If you start working for the employer after the policy effective date – 30 days

Benefits amounts for eligible employees shall be determined in accordance with the following schedule:

Benefit	Benefit Amount
Employee Basic Life	2.0 Times Annual Salary rounded to the next higher $1,000, if not exact, to a maximum of $500,000.
Employee Basic Accidental Death & Dismemberment	2.0 Times Annual Salary rounded to the next higher $1,000, if not exact, to a maximum of $500,000.
Group Life Accelerated Benefits	75% up to $250,000
AD&D Coma Rider	5% per month for 11 months
AD&D Exposure & Disappearance Rider	AD&D benefit payable after 1 year of accidental disappearance
AD&D Repatriation Rider	10% up to $5,000
AD&D Seat Belt & Air Bag Rider	Seat Belt: 10% up to $10,000 Air Bag: 10% up to $10,000

If a covered person is eligible for any amount in excess of the guaranteed issue amount shown below, the employee must furnish evidence of insurability, which is subject to our approval.

Benefit	Guaranteed Issue Amount
Employee Basic Life	The lesser of 2.0 Times Annual Salary rounded to the next higher $1,000, if not exact, or $300,000.
Employee Basic Accidental Death & Dismemberment	The lesser of 2.0 Times Annual Salary rounded to the next higher $1,000, if not exact, or $300,000.

Reductions, Terminations, and Special Provisions

Employee Basic Life	For all employees who retire under the employer's retirement plan before age 70, benefits will reduce to $5,000 upon retirement. Benefits will terminate at age 70. For all other employees who are not eligible for the employer's retirement plan, benefits will reduce to 66 2/3% at age 65 and to 33 1/3% at age 70. Terminates at retirement.
Employee Basic Accidental Death & Dismemberment	Reduces to 66 2/3% at age 65 and to 33 1/3% at age 70. Terminates at retirement.

Definitions

The terms listed, if used, will have these meanings.

Accident or Injury mean accidental bodily injury sustained by the covered person while insured under the policy which is the direct cause of the loss, independent of disease or bodily infirmity or any other cause.

Active Work or Actively at Work mean the expenditure of time and energy for the policyholder or an associated company at your usual place of business on a full-time basis. If you are not working on a day your coverage would otherwise take effect, you will be considered to be at active work on that day only if:

1. when that work day begins, it would be reasonable to expect that you would be physically and mentally able to complete a full-time week of work in your regular occupation; and
2. you are not disabled; and
3. your contract of employment, if applicable, remains active; and
4. you are not on an unapproved, administrative or disciplinary leave; and
5. you return to work at the end of a paid break or vacation period.

Annual Salary means your annual base rate of pay, excluding any overtime pay, bonuses, or other extra pay. If your pay is from commissions, your annual salary will be based on your average commissions for the prior 12 months.

Associated Company means any company shown in the application which is owned by or affiliated with the policyholder.

Beneficiary means the person or entity you choose to receive your amount of insurance at your death.

Contributory means you pay part of the premium.

Covered Person means an eligible employee or the employee's dependents whose insurance has become and remains effective under all the conditions and provisions of the policy. Covered persons do not include contract, temporary, seasonal, or part-time workers.

Eligible Class means a class of persons eligible for insurance under the policy. This class is based on employment or membership in a group.

Eligible Persons means a person who:

1. is a citizen of the United States of America (U.S.) or Canada, who either:
   a. resides in the U.S. or Canada; or
   b. is stationed outside the U.S. or Canada for a period of less than 6 months; or
2. is a foreign national residing in the U.S. and meets all of the following requirements:
   a. has a valid permanent residency visa;
   b. participates in U.S. Social Security; and
   c. is covered by Workers' Compensation.

Employee means an eligible person who is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the policyholder or an associated company; or
4. a retiree, if listed as eligible in the policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the above conditions.

Employer means the policyholder.

Evidence of Insurability means a signed health and medical history form provided by us, a medical examination, if requested, and any additional information and attending physicians' statements that we may require.

Family Member means a person who is a parent, spouse, child, sibling, domestic partner, grandparent, grandchild, step-child, step-parent, step-sister, step-brother, father-in-law, or mother-in-law of the covered person; or spouses, as applicable, of any of these.

Full-time means working at least the number of hours indicated in the Schedule of Insurance for Full-time employment.

Gender – The use of the male pronoun also includes the female.

Home Office means the principal office of USAble Life in Little Rock, Arkansas.

Hospital means a facility supervised by one or more physicians and operated under state and local laws. It must have 24-hour nursing service by registered graduate nurses. It may specialize in treating alcoholism, drug addiction, chemical dependency, or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged.

Hospital Confined and Hospital Confinement mean staying in a hospital as a registered inpatient for 24 hours a day.

Material Duty or Material Duties mean the sets of tasks or skills required generally by employers from those engaged in an occupation. We will consider one material duty of your regular occupation to be the ability to work for an employer on a full-time basis as defined in the policy.

Noncontributory means the policyholder pays the premium.

Occupation means a group of jobs:

1. in which a common set of tasks is performed; or
2. which are related in terms of similar objectives and methodologies, and which may be related in terms of materials, products, worker actions, or worker characteristics.

Physician means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. This includes a person whom we are required to recognize as a physician by the laws or regulations of the governing jurisdiction. However, neither you nor a family member will be considered a physician.

Plan means the policy and certificates of insurance provided for covered persons.

Plan Administrator means the employer that sponsors the plan for the benefit of its employees and eligible dependents.

Policy means the group policy issued by us to the policyholder that describes the benefits for which you may be eligible.

Policyholder means the entity to which the policy is issued.

Regular Care means you personally visit a physician as often as is medically required to effectively manage and treat your disabling condition(s), according to generally accepted medical standards; and you are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the sickness or injury causing your disability must be given by a physician whose specialty or experience is appropriate.

Regular Occupation means the occupation in which you were working immediately prior to becoming disabled.

Retiree or Retirement means you begin receiving retirement benefits from either:

1. a retirement plan sponsored by your employer, the policyholder, or an associated company, or
2. a government plan.

Sickness means a disease or illness, including pregnancy.

United States of America means the fifty (50) states of the United States and the District of Columbia. It does not include territories of the United States.

Waiting Period is the number of continuous days of service during which you must be an active, full-time employee in a class eligible for insurance before you become eligible for coverage.

We, Us, and Our mean USAble Life.

You and Your mean an employee of the policyholder or an associated company who has met all the eligibility requirements for coverage, and is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the employer, or associated company covered under the policy; or
4. a retiree, if listed as eligible in the group Policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the conditions listed above.

Eligibility and Effective Date Provisions

Eligible Employee

If you are working on a full-time basis for the employer, you are eligible for insurance after completion of the required waiting period, provided you are in a class of employees who are included.

Employee Eligibility Date

If you are working for your employer in an eligible class, the date you are eligible for coverage is the latest of the following dates:

1. the policy effective date;
2. the day after you complete any waiting period shown in the Schedule of Insurance by continuous service with the employer, the policyholder, or an associated company;
3. the date the policy is changed to include your class; or
4. the date you become a member of a class eligible for insurance.

Rehires: If you were insured under this policy and your insurance terminated due to termination of employment or eligibility, and you again become an eligible employee within 12 months, there is no waiting period.

Effective Date of Employee Insurance

You must use forms approved by us when applying for insurance.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When your Employer pays 100% of the cost of your coverage under the policy, you will be covered at 12:01 a.m. at your employer's address on your eligibility date.
2. When you and your Employer share the cost of your coverage under the policy or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. at your employer's address on the latest of the following dates:
   a. on your eligibility date, if you enroll for insurance within 31 days after the date you first become eligible for coverage; or
   b. on the first day of the policy month following the date we approve your application if you do not apply for insurance within 31 days after your eligibility date.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, your coverage will be effective on the first day of the policy month following the date we approve your application.

Delayed Effective Date

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, it will take effect on the day you return to active work. If your insurance is scheduled to take effect on a non-working day, your active work status will be based on the last working day before the scheduled effective date of your insurance.

Changes in Coverage Provisions

When Coverage Amounts Change (Redetermination Date)

The policy redetermines your amount of insurance on the first of the policy month after a change occurs. If benefits are based on your salary, the policyholder must report updates to all covered person's earnings as they occur. Changes to a covered person's earnings are subject to any proof of insurability requirements of the policy. As of the policy's redetermination date, we use a covered person's salary or earnings on record with us to: (a) set rates; (b) set benefit amounts and limits; and (c) calculate premium payable under the policy.

Delayed Effective Date of Change

You must be actively at work on a full-time basis on the redetermination date. If you are not, your coverage amount will not change until the date you return to active work on a full-time basis. Changes in salary or earnings will not apply to a recurring disability.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

Changes to the Policy

Any increase or decrease in coverage because of a change in the plan of insurance will become effective on the date of the change. The Delayed Effective Date provision will apply to an increase.

Termination Provisions

Termination of Employee Insurance

Your insurance will terminate at 12:00 midnight on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date the policy terminates, or the date a specified benefit terminates;
3. the date you cease to be a member of a class eligible for insurance;
4. the date you cease to be actively at work;
5. if your coverage is continued under the Waiver of Premium provision, the date specified under "Termination of the Extended Insurance Benefit."

Continuation of Insurance

If you are unable to perform active work for a reason shown below, the policyholder may continue your insurance, except for any Accidental Death and Dismemberment coverage, on a premium-paying basis provided you remain in other respects a member of an eligible class. The continuance cannot be more than the maximum continuance shown below. The employer must act so as not to discriminate unfairly among employees in similar situations.

The maximum continuance for insurance is the longest applicable period described below:

1. six months following the date active work stopped due to lay-off or approved leave of absence, or
2. twelve months following the date active work stopped due to your total disability.

Total Disability for Continuation of Insurance means that you are under the regular care of a physician, and prevented by injury or sickness from performing all of the material duties of your regular occupation.

Claim Provisions

Notice of Loss

Written notice of claim must be given to us at our Home Office within 30 days after a loss occurs or begins, or as soon after the loss as is reasonably possible to do so, but not later than one (1) year from the time notice is required. The notice should identify the covered person and the nature of the loss.

Within 15 days after the date of your notice, we will send you claim forms. The forms must be completed and sent to our Home Office. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.

Proof of Loss

For any loss for which the policy provides periodic payment contingent upon continuing loss, written proof of loss must be given to us within 90 days after the termination of the period for which we are liable. For any other loss covered by the policy, written proof of loss must be given to us within 90 days after the date of such loss. Failure to furnish proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time. Such proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof was otherwise required.

Physical Examination and Autopsy

We have the right to have a physician of our choice examine the covered person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.

Payment of Claims

All benefits payable under this policy will be payable immediately upon receipt of due written proof of such loss.

If included, Dismemberment benefits will be paid to you. Employee Life insurance and Accidental Death benefits will be paid to the person(s) named by you to receive them.

If you failed to name a beneficiary or if no named beneficiary is living at your death, refer to the "Beneficiary" provision below. At our option, up to the maximum allowable by the state laws of the covered person's state of residence may be paid to any person who incurred funeral or other expenses related to the last illness or death of the covered person.

Beneficiary

Your beneficiary will be the person(s) you name in writing to receive any amount of insurance payable due to your death. The beneficiary's name is on record in our Home Office, or in the policyholder's office if the group is self-administered.

You may name or change a beneficiary by giving us written notice at our Home Office (or by giving the policyholder written notice if the group is self-administered) on a form acceptable to us. When we receive the notice, it will be effective on the date made, subject to any payment we may have made before we receive it.

If there is no named beneficiary living at your death, we may pay, at our discretion, any amount due to one of the following classes of survivors: (1) your spouse; (2) your surviving children in equal shares; (3) your mother and/or father; (4) your brother and/or sister; or (5) your estate.

Assignment

You may transfer your rights to name or change the beneficiary to someone else by assignment. An assignment will affect us only if it is in writing on a form acceptable to us, and is received at our Home Office. When we record it, the assignment will take effect as of the date you made it. The assignment will be subject to any action we may have taken before we record it. We take no responsibility for the validity of any assignment.

Claims of Creditors**:** To the extent allowed by law, proceeds will not be subject to any claims of a beneficiary's creditors.

Authority

The policyholder delegates to us and agrees that we have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the policy.

We decide: (a) if a covered person is eligible for this insurance; (b) if a covered person meets the requirements for benefits to be paid; and (c) what benefits are to be paid by the policy. We also interpret how the policy is to be administered. What we pay and the terms for payment are explained in this certificate.

Limit on Legal Action

No action at law or in equity may be brought against the policy until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations has expired, but, in any case, not after three (3) years from the date of loss.

Review Procedure

You must request, in writing, a review of a denial of your claim within 180 days after you receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit written comments, documents, records and other information relating to your claim for benefits.

We will review your claim after receiving your request and send you a notice of our decision within 45 days after we receive your request, or within 90 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant provisions of the policy. We will also advise you of your further appeal rights, if any.

Subrogation and Right of Reimbursement

The plan assumes and is subrogated to your legal rights to recover any payments the plan makes for benefits, when a covered sickness or injury resulted from the action or fault of a third party. The plan's subrogation rights include the right to recover the amount of benefits paid to you.

The plan has the right to recover any and all amounts equal to the plan's payments from:

1. the insurance of the injured party;
2. the person, company (or combination thereof) that caused the sickness or injury, or any insurance company; or
3. any other source, including disability benefit coverage.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The plan's recovery will not be reduced by your negligence, nor by attorney fees and costs you incur.

Priority Right of Reimbursement

Separate and apart from the plan's right of subrogation, the plan shall have first lien and right to reimbursement. This priority right of reimbursement supersedes your right to be made whole from any recovery, whether full or partial. You agree to reimburse the plan 100% first for any and all benefits provided through the plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

1. any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from your own insurance and/or from the third party (or their insurance);
2. any auto or recreational vehicle insurance coverage or benefits including, but not limited to disability benefit coverage; and
3. business and homeowner disability insurance coverage or payments.

The plan may notify those parties of its lien and right to reimbursement without notice to or consent from any covered person.

This priority right of reimbursement will not be reduced by attorney fees and costs you incur.

The plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available disability insurance coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

Notice and Cooperation

You are required to notify us promptly if you are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable us to protect the plan's rights under this section. You are also required to cooperate with us and to execute any documents that we, acting on behalf of the policyholder, deems necessary to protect the plan's rights under this section.

You shall not do anything to hinder, delay, impede or jeopardize the plan's subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the plan to withhold any and all benefits due you under the plan. This is in addition to any and all other rights that the plan has pursuant to the provisions of the plan's subrogation rights and/or priority right of reimbursement.

If the plan has to file suit, or otherwise litigate to enforce its subrogation rights and/or priority right of reimbursement, you are responsible for paying any and all costs, including attorneys' fees, the plan incurs in addition to the amounts recovered through the subrogation rights and/or priority right of reimbursement.

Legal Action and Costs

If a covered person settles any claim or action against any third party, that covered person shall be deemed to have been made whole by the settlement and the plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. The covered person shall hold any such proceeds of settlement or judgment in trust for the benefit of the plan. The plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the covered person in such circumstances.

Additionally, the plan has the right to sue on the covered person's behalf, against any person or entity considered responsible for any condition resulting in benefits paid or to be paid by the plan.

Settlement or Other Compromise

The covered person must notify the plan prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the plan's rights so that the plan may be present and protect its subrogation rights and/or priority right of reimbursement.

The plan's subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against the covered person.

The right of subrogation and the right of reimbursement are based on the plan language in effect at the time of judgment, payment, or settlement.

The plan, or its representative, may enforce the subrogation and priority right of reimbursement.

Alternate Dispute Resolution Procedures

This dispute resolution procedure ("procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all disputes with us. Such disputes include any matters that cause you to be dissatisfied with any aspect of your relationship with us, including any claim, controversy, or potential cause of action you may have against us. Please contact the Dispute Resolution office at (800) 648-0271 if you have any questions about this section of the certificate or to begin the dispute resolution process.

The following terms are applicable to all disputes:

1. This procedure is the exclusive method of resolving any disputes.
2. The procedure can only resolve disputes that are subject to our control.
3. This procedure will be governed by the Employee Retirement Income Security Act of 1974 ("ERISA"); Rules and Regulations for Administration and Enforcement; Claims Procedure (the "Claims Regulation"). That includes the definition of an adverse benefit determination, which is defined as any denial, reduction, termination or failure to provide or make payment for what you believe should be a covered benefit.
4. You may request a form from our Dispute Resolution office to authorize another person to act on your behalf concerning a dispute.
5. We may elect to skip one or more of the steps of this procedure if it is determined that step will not help to resolve the dispute.
6. Any dispute will be resolved in accordance with the terms of this certificate, applicable state or Federal laws and regulations.
7. You must begin the dispute process within 180 days from the date you receive notice of an adverse benefit determination. If you do not initiate the dispute process within that 180 day period, you give up the right to take any action based on that Dispute.

Description of the Procedure

Inquiry

You should contact our Dispute Resolution office to discuss and attempt to resolve any issues regarding a dispute. We hope that this informal process will resolve your questions or concerns.

Appeals

If you are not satisfied with the response to your inquiry, you may submit a written request (an "appeal") to the Office of the Appeals Coordinator, USAble Life, P.O. Box 1650, Little Rock, AR 72203-1650, asking that we reconsider an adverse benefit determination. Please contact the Dispute Resolution office if you have any questions about how to submit an appeal to us. You are not required to use a specific form, but you may request that the Dispute Resolution office send you a blank appeal form to ensure that you provide the information that will be needed to review your appeal.

We will assign a coordinator to review your appeal. The appeal coordinator is an individual with appropriate expertise who is neither the individual who made the adverse benefit determination, nor a subordinate of that individual.

The appeal coordinator may request that you submit additional information concerning your grievance. The appeal coordinator will also consider information submitted by others, including information requested from other USAble Life representatives. The appeal coordinator will have full discretionary authority to make eligibility, benefit or claim determinations and construe the terms of the policy. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the policy is not governed by ERISA.

We will make a decision within 60 days after receiving your appeal concerning a claim determination.

The appeal coordinator will send you a written decision concerning your appeal. The appeal coordinator's decision will include: a statement of the coordinator's understanding of your appeal; a statement explaining the basis of the decision; and a list of the documents or information upon which that decision was based. We will send you a copy of the listed documents, without charge, if you make a written request for such documents.

Post Appeal Procedure

If you are still not satisfied after completing the appeal procedure, you have the right to bring a civil action against us to obtain the remedies available pursuant to Sec. 502(a) of ERISA (an "ERISA Action") after completing the mandatory appeal process. Those ERISA remedies will apply to this policy even if your plan is not otherwise governed by ERISA. If you agree to arbitrate a dispute, we agree to suspend (or toll) any time periods affecting your right to bring an ERISA Action against us related to that dispute, until the arbitration has been completed.

You may request that the dispute be submitted for resolution by arbitration. That arbitration request must be submitted, in writing, to USAble Life's General Counsel within sixty (60) days after you receive the appeal coordinator's decision.

The dispute will be submitted to arbitration in accordance with the rules of the American Arbitration Association, unless we both agree to use an alternative dispute resolution administrator or procedure. The arbitration will be conducted before a single arbitrator.

We will pay the filing fee charged by the administrator and the arbitrator. You will be solely responsible for any other costs that you incur to participate in the arbitration process, including your attorney's fees. The filing fee and arbitrator's fees may be reallocated as part of an arbitration award, in whole or in part, at the discretion of the arbitrator.

The arbitration will be conducted in a location where it is reasonably convenient for you to participate. If we cannot agree concerning a convenient location, the administrator or arbitrator, if appointed, shall have the discretion to decide where the arbitration will be conducted.

The arbitrator: (a) shall consider the dispute individually and shall not certify or consider multiple disputes as part of a class action; (b) shall be required to issue a reasoned written decision explaining the basis of his or her decision and the manner of calculating any award; (c) shall limit his or her decision to deciding if our adverse benefit decision was arbitrary or capricious based on ERISA standards; (d) may not award punitive, extra-contractual, treble or exemplary damages unless permitted to do so by applicable statutes or regulations; (e) may not vary or disregard the terms of the policy; and (f) shall be bound by controlling law; when issuing a decision concerning the dispute.

The arbitrator shall limit discovery to the extent possible consistent with the objective of completing the arbitration in a fair, prompt, and cost effective manner. Emergency relief such as injunctive relief may be awarded by the arbitrator.

Contact Information

General Counsel
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: [(800) 648-0271]
Email: AppealCoordinator@usablelife.com

Office of the Dispute Resolution Coordinator
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: [(800) 648-0271]
Email: AppealCoordinator@usablelife.com

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General Provisions

Entire Contract

This certificate is furnished in accordance with and subject to the terms of the policy. The entire contract consists of the policy, which includes the application, any amendments and addenda; this certificate; your enrollment form, if required; and any riders or endorsements. No change in the policy will be effective until approved by one of our officers. This approval can only be in writing and must be noted on or attached to the policy. No agent has authority to change the policy or certificate or to waive any of their provisions.

Any statement made by you or the policyholder is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about you or the policyholder's plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

Incontestability

Unless the premiums have not been paid, the validity of the policy cannot be contested after it has been in force for two years.

Any statement made by the policyholder or a covered person will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the covered person or the beneficiary.

No statement, except fraudulent misstatement, made by a covered person about insurability will be used to deny a claim for a loss incurred or disability starting after coverage has been in effect for two years.

No claim for loss starting two or more years after the covered person's effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Agency

Neither the policyholder, any employer, any associated company, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

Unpaid Premium

We may deduct any unpaid premium then due from the payment of a claim under this certificate.

Refund of Premium

On the death of the covered person, proceeds payable hereunder shall include the amount of unearned premium paid beyond the end of the policy month in which death occurred. Payment shall be made in one lump sum no later than 30 days after proof of the covered person's death has been furnished to us.

Conformity with State Statutes

If the provisions of this certificate do not conform with the laws of the state in which you reside on the certificate effective date, they are hereby amended to conform with the minimum requirements of the statutes of that state.

Policy Management

Efficient management of the policy requires the joint efforts of the policyholder, USAble Life, and each covered person. Each party has certain duties to bring about the effective administration of the policy.

Duties of the Policyholder: The policyholder's primary duties under the policy are listed below.

1. Give us prompt, written notice of any change in business of the policyholder and employer. This includes, but is not limited to: (a) the type of business; (b) addition or deletion of an associated company; or (c) financial status due to bankruptcy; merger; acquisition; or dissolution.
2. Give us pertinent records for all covered persons. This includes, but is not limited to: (a) hire dates; (b) eligibility dates; (c) salaries; (d) occupations; and (e) birth dates. Give us updates of such records as needed.
3. Give us prompt notice of a covered person's disability. This notice should be given as soon as possible after the date of injury or start of sickness. The most effective time for such notice is when the covered person has not been able to perform active work for 30 days.
4. Give us occupational data for all disabled covered persons. This includes, but is not limited to: (a) job descriptions and analyses; and (b) environmental factors.

Duties of Covered Persons and Beneficiaries: Your and your beneficiary's primary duties under the policy are listed below:

1. Give notice and proof of loss as soon as possible after the date of your injury or sickness, or the date of your death, or the death of a covered dependent, if applicable.
2. Give a complete account of the details of your injury or sickness or the death on a form approved by us.
3. Provide any other official documents to review the loss such as a certified death certificate, investigating officer's report, or medical records.
4. Allow release of medical and income data needed to adjudicate your claim.
5. Provide evidence of the regular care of a physician, if necessary.
6. Promptly report to us any changes in your status such as your address or telephone number, or if you return to work or are no longer disabled.
7. If benefits are overpaid, reimburse such overpayment within 60 days of the date benefits were overpaid.
8. Provide proof of your earnings for the period prior to a loss.

Fraud

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the policy and recovery of any amounts we have paid.

Employee Term Life Insurance

Death Benefit

We will pay your beneficiary the amount of insurance in force on the date of death, as shown in the Schedule of Insurance, when we receive all required proof of loss, including written proof of your death acceptable to us and a completed claim form.

Conversion Privilege for Life Insurance

Conversion upon Termination of Employment or Eligibility

For Employees
You may convert all or part of your life insurance to an individual policy of life insurance, other than Term,

1. if all or part of it stops for any reason; unless
2. it stops because you did not pay any required premiums.

The amount you may apply for may not be more than:

1. the life amount then in force; or
2. that part of the life amount which has stopped, whichever is less.

Accidental death and dismemberment, disability or any other supplemental coverage for which you are eligible under this policy may not be converted.

Conversion upon Termination or Amendment of Group Policy

Any covered person may convert a limited amount of life insurance if he has been continuously insured under the policy for at least five (5) years and his insurance ends due to termination or amendment of the policy.

The amount you may convert in this case is the smaller of the following:

1. the amount of life insurance which terminates, less the amount you became eligible for under any group policy within 31 days after this insurance terminated; or
2. $10,000.

Conversion Coverage

Any covered person may convert his life insurance to any policy we are issuing for the purpose of conversions other than Term. The conversion policy will not have disability or other supplementary benefits. No evidence of insurability will be required. The premium will be based on the amount and the form of the conversion policy, and on the covered person's class of risk and age on the date the conversion takes effect.

A conversion policy is in lieu of all other benefits under this policy. If you qualify for the Extended Insurance Benefit, any conversion policy issued will be canceled. Premiums paid for the converted policy will be returned.

The conversion policy will take effect on the 32nd day after the insurance terminates.

Notice and Application Required

Written application and the first premium payment for the conversion policy must be received in our Home Office within 31 days after the covered person's insurance terminates. If you are not given notice of the right to convert by the 16th day of the 31 day conversion period, you will have an additional period in which to apply for conversion. The additional period will end 15 days after you are given notice, but not more than 61 days after the date the insurance under the policy ended.

Nothing in the policy will continue coverage for more than 31 days following the date coverage ends under the policy. Written notice, contained in this certificate of insurance and given to you at any time, or mailed by the policyholder to your last known address will be considered sufficient written notice to you. It is the responsibility of the policyholder to give such notice to you.

Conversion Period Death Benefit

If the covered person dies within the 31 days allowed for making application to convert, we will pay the amount he was entitled to convert. We will do this whether or not application was made.

Life Insurance – Waiver of Premium

This section applies to the Basic Life Insurance Benefit only.

Extended Insurance Benefit (Waiver of Premium)

We will continue the term life insurance in force without premium payment if you become totally disabled provided:

1. you are insured under this plan and are actively at work on or after the effective date of the plan; and
2. your total disability begins before age 70; and
3. you provide us with proof of total disability as required; and
4. you are still totally disabled when you submit the proof of disability.

Amount of Life Insurance

The amount of life insurance continued will be the amount in force on the date you became totally disabled. This amount will be reduced or terminated based on the Schedule of Insurance in effect on the date of total disability. This amount will not be increased while you remain totally disabled.

Definition of Total Disability

For the purposes of waiver of premium, "total disability" or "totally disabled" means that you are under the regular care of a physician, and prevented by injury or physical or mental sickness from performing the material duties of any gainful occupation.

Gainful Occupation means any employment that exists in the national economy that you may be expected to follow based on your education, training, experience, age, and physical and mental capacity, and from which you are expected to earn at least 80% of your pre-disability earnings within 12 months of your return to active work.

Proof of Total Disability

Upon receipt of Notice of Loss, we will provide forms which you must use when giving us proof of total disability. (See "Notice of Loss" under the Claim Provisions.) You must give us proof no later than 12 months after the date you became totally disabled. We may at any time require proof that total disability continues. You must give us proof of continuing disability within 60 days after our request. After you have been totally disabled for more than two years from the date of total disability, we will not request proof more than once a year. We may require that you be examined at our expense by a physician of our choice.

Death While Totally Disabled

If you die while your life insurance is being continued under this provision, we will pay the amount of insurance if we receive proof:

1. of your death; and
2. that total disability was continuous from the date it began to the date of death.

Termination of the Extended Insurance Benefit

You will no longer be eligible for the Extended Insurance Benefit and your life insurance will terminate on the earliest of the following dates:

1. the date you cease to be totally disabled. But, if you are still eligible for life insurance when you return to active work, your life insurance may be continued in force if premium payments are resumed. If this is done, any increased amount of life insurance you may

then be eligible for will take effect as described in the Effective Date of Insurance provision; or

2. the last day of the 60 day period following our request for proof of total disability, if you do not give us proof or you refuse to take a medical exam; or
3. the date you attain age 70.

If your life insurance terminates while you are covered under this provision, you will be eligible to convert that coverage as of the termination date. You may convert no more than the amount of term life insurance that was in force on you on that date. (See “Conversion Privilege for Life Insurance” provision.)

Accidental Death & Dismemberment Insurance

This section applies to the Basic Accidental Death & Dismemberment (AD&D) Benefit.

For Basic AD&D, you are the only covered person under this benefit.

If a covered person suffers a loss described below, we will pay the amount of insurance that applies. You or your beneficiary must give us proof that:

1. injury occurred while the insurance was in force under this section;
2. loss occurred within 365 days after the injury; and
3. loss was due to injury independent of all other causes.

Amount of Insurance

If a covered person suffers a specified loss, we will pay the benefit set opposite such loss; provided, however, that if the covered person sustains more than one such loss as the result of any one accident, we will pay only the one largest amount to which the covered person is entitled. In paying the benefit, we will consider only losses sustained while insured under this benefit.

Loss of Life .....100% of the AD&D Amount

Loss of Two or More Members.....100% of the AD&D Amount

Loss of One Member.....50% of the AD&D Amount

Loss of Thumb and Index Finger
of the Same Hand .....25% of the AD&D Amount

Member means hand, foot, sight, speech, or hearing.

Loss of sight means total and irrecoverable loss of sight.

Loss of hands or feet means total and irrecoverable loss due to severance at or above the wrist or ankle, unless the state in which the policy is issued defines the loss differently.

Loss of Thumb and Index Finger means total and irrecoverable loss at the proximal phalanx.

Loss of speech means a total and irrecoverable loss of audible communication.

Loss of hearing means permanent total deafness in both ears such that it cannot be corrected to any functional degree by any aid or device.

Exclusions

We will not pay a benefit for a loss caused directly or indirectly by:

1. disease, bodily or mental infirmity, or infection (except bacterial infection of a visible injury);
2. war or any act of war, or while serving in the armed forces of any country or international authority;
3. suicide or intentional, self-inflicted injury, whether sane or insane;
4. your active participation in a riot or insurrection;
5. your voluntary commission of, or attempting to commit, an assault or felony; or participating in an illegal occupation;
6. your voluntary use of any drug, hallucinogen, controlled substance, or narcotic unless taken as prescribed by a physician;
7. travel or flight in, or descent from, any aircraft unless as a fare paying passenger on a commercial airline flying between established airports on: (a) a scheduled route, or (b) a charter flight;

8. your being intoxicated as defined by the laws of the jurisdiction in which the accident occurred. Conviction is not necessary for a determination of being intoxicated.

Participation in a riot shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.

Riot shall include all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

War means declared or undeclared war or a conflict involving the armed forces of any country, group of countries, governments, or international organization.

Group Life Accelerated Benefit

This section applies to the Basic Life Insurance Benefit only.

Notice of Possible Tax Consequences

Please be advised that receipt of the accelerated benefits may be taxable. Any person who receives accelerated benefits should consult his personal tax advisor.

The receipt of accelerated benefit payments may adversely affect the covered person's eligibility for Medicaid or other government benefits or entitlements.

Definitions

"Terminal Illness" means a medical condition:

1. which is expected to result in the covered person's death within 12 months; and
2. from which the covered person is not expected to recover.

Eligibility

All covered employees under age 70 who are insured for a minimum of $10,000 of life insurance under the policy are eligible.

A covered employee is eligible for the accelerated benefit only if he becomes and remains insured for life insurance under the policy.

Accelerated Benefit

The accelerated benefit is an advance payment to the covered person who:

1. is terminally ill; and
2. elects to receive part of his life insurance benefit payable under the group policy, subject to the maximum benefit amounts stated on the Schedule of Insurance.

We will pay an accelerated benefit to you when we receive the following:

1. a written request for payment of the accelerated benefit; and
2. proof that the covered person is terminally ill and his illness is expected to result in his death within 12 months.

The accelerated benefit will be paid only once for each eligible covered person, and in one lump sum to you before death occurs.

Cost of Providing the Accelerated Benefit

There is no cost associated with providing the accelerated benefit.

Amount of Accelerated Benefit

The maximum accelerated benefit will be the lesser of:

1. 75% of the covered person's life insurance amount; or
2. $250,000.

If the covered person's life insurance amount is scheduled for a reduction within 12 months after the date you request the payment of the accelerated benefit, the maximum accelerated benefit will be based on the reduced amount.

Irrevocable Beneficiary

For the purpose of the Accelerated Benefit provision, an irrevocable beneficiary is a named beneficiary whose rights to the employee's life insurance proceeds are vested and whose rights cannot be cancelled by the employee unless the irrevocable beneficiary consents.

Conditions and Requirements for Payment of the Accelerated Benefit

You must request payment of an accelerated benefit in writing.

Proof that the covered person is terminally ill must be provided to us. The proof must be certified by a licensed physician and in a form that is satisfactory to us. We are not obligated to ask for any proof. Any delay in submitting proof will not cause a request to be denied if the proof is given to us as soon as reasonably possible.

After receipt of such proof, we may require the covered person to be examined by a licensed physician of our choice, at our expense. If there is a disagreement between the two physicians, we may require the covered person to be examined by another licensed physician of our choice, at our expense. The decision of the third physician will be final.

Effect of Payment of an Accelerated Benefit on Policy Provisions

The covered person's amount of life insurance under the policy will be reduced by the amount of any accelerated benefit that has been previously paid.

The following will be based on the reduced life insurance amount:

1. the amount of life insurance payable to the beneficiary when the covered person dies;
2. the amount of life insurance the covered person can convert under the policy; and
3. the premiums payable for the covered person's life insurance under the policy after an accelerated benefit is paid to you, if such premiums are not waived.

The payment of an accelerated benefit will not affect the amount of the covered person's Accidental Death and Dismemberment Benefits under the group policy, if any.

Exclusions

We will not pay an accelerated benefit if:

1. the covered person has made an absolute assignment of his life insurance under the policy and we do not receive written consent by the absolute assignee;
2. all or part of the covered person's life insurance under the group policy is to be paid to his children or former spouse as part of a court approved divorce agreement;
3. the covered person has made an irrevocable beneficiary designation of his life insurance under the policy and we do not receive written consent by the irrevocable beneficiary; or
4. the terminal illness is a result of intentional self-inflicted injury or attempted suicide, committed while sane or insane.

Date Insurance Ends under this Benefit

A covered person's insurance under this benefit will end at the earliest of:

1. the date the accelerated benefit is paid to you on the covered person's behalf;
2. the date the covered person's life insurance ends under the policy; or
3. the policy anniversary on which the covered person is age 70.

Important Notice

The following information is provided to assist you in answering any questions you might have:

Soliciting Agent
The name, address and telephone number of our soliciting agent is available to you, if needed, by calling our Customer Service Department at [(800) 370-5856].

USAble Life

USAble Life
P. O. Box 1650
Little Rock, AR 72203-1650
Toll Free [(800) 370-5856]

If we fail to provide you with reasonable and adequate service, you may contact:

Arkansas Insurance Department

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Phone (501) 371-2640 or
Toll Free 1-800-852-5494

We appreciate the opportunity to serve your insurance needs.

ERISA Information

Plan Sponsorship and Administration

The plan was established by the actions of your employer, which continues to act as Plan Sponsor and Plan Administrator. Your employer, as Plan Administrator, performs the functions of distributing Plan notices and information to employees and other Plan participants, coordinates employees' and eligible dependents' enrollment in the Plan, and transmits Plan premium payments.

ERISA Rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.
4. Neither your employer, nor any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
5. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
6. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, provided that you have first followed the Plan's designated appeals procedure before bringing suit.
7. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees.
8. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
9. If you have any questions about your Plan, you should contact the Plan Administrator.
10. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

USAble Life

[320 W. Capitol] • P.O. Box 1650 • Little Rock, AR 72203-1650
[(501) 375-7200 • (800) 648-0271]

CERTIFICATE OF INSURANCE

Group Term Life and Accidental Death & Dismemberment

Policyholder: SIMMONS FIRST NATIONAL BANK

Class: 003 – BOARD OF DIRECTORS MEMBERS

State of Residence: ARKANSAS

This is to certify that USAble Life has issued and delivered the Group Term Life and Accidental Death & Dismemberment Insurance Policy to the Policyholder.

The policy insures the employees and their dependents, if elected, of the policyholder who:

1. are eligible for the insurance;
2. become insured; and
3. continue to be insured;

according to the terms of the policy.

The terms of the policy that affect your insurance are contained in the following pages.

This Certificate of Insurance is a part of the policy. This certificate replaces any other that USAble Life may have issued to the policyholder to give to you under the Group Insurance Policy specified herein.

Signed for USAble Life:

James L. Tourse — Secretary

Jason Ham — President

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Schedule of Insurance

Policyholder:	SIMMONS FIRST NATIONAL BANK
Group Policy Number:	50001328
Policy Effective Date:	September 1, 2010* *This certificate replaces any certificate issued before the date shown.
Eligible Class:	Class 003 – BOARD OF DIRECTORS MEMBERS
Full-time Employment:	30 hours weekly
Renewal Date:	September 1, 2012

Waiting Period: You will be eligible for coverage on the first of the policy month following completion of the following period of continuous active work:

1. If you are working for the employer on the policy effective date – 0 days
2. If you start working for the employer after the policy effective date – 30 days

Benefits amounts for eligible employees shall be determined in accordance with the following schedule:

Benefit	**Benefit Amount**
Employee Basic Life	$50,000
Employee Basic Accidental Death & Dismemberment	$100,000
Group Life Accelerated Benefits	75% up to $250,000
AD&D Coma Rider	5% per month for 11 months
AD&D Exposure & Disappearance Rider	AD&D benefit payable after 1 year of accidental disappearance
AD&D Repatriation Rider	10% up to $5,000
AD&D Seat Belt & Air Bag Rider	Seat Belt: 10% up to $10,000 Air Bag: 10% up to $10,000

Reductions, Terminations, and Special Provisions	
Employee Basic Life	Benefits reduce 50% at age 65 and terminate at age 70.
Employee Basic Accidental Death & Dismemberment	Benefits reduce 50% at age 65 and terminate at age 70.

Definitions

The terms listed, if used, will have these meanings.

Accident or Injury mean accidental bodily injury sustained by the covered person while insured under the policy which is the direct cause of the loss, independent of disease or bodily infirmity or any other cause.

Active Work or Actively at Work mean the expenditure of time and energy for the policyholder or an associated company at your usual place of business on a full-time basis. If you are not working on a day your coverage would otherwise take effect, you will be considered to be at active work on that day only if:

1. when that work day begins, it would be reasonable to expect that you would be physically and mentally able to complete a full-time week of work in your regular occupation; and
2. you are not disabled; and
3. your contract of employment, if applicable, remains active; and
4. you are not on an unapproved, administrative or disciplinary leave; and
5. you return to work at the end of a paid break or vacation period.

Associated Company means any company shown in the application which is owned by or affiliated with the policyholder.

Beneficiary means the person or entity you choose to receive your amount of insurance at your death.

Contributory means you pay part of the premium.

Covered Person means an eligible employee or the employee's dependents whose insurance has become and remains effective under all the conditions and provisions of the policy. Covered persons do not include contract, temporary, seasonal, or part-time workers.

Eligible Class means a class of persons eligible for insurance under the policy. This class is based on employment or membership in a group.

Eligible Persons means a person who:

1. is a citizen of the United States of America (U.S.) or Canada, who either:
   a. resides in the U.S. or Canada; or
   b. is stationed outside the U.S. or Canada for a period of less than 6 months; or
2. is a foreign national residing in the U.S. and meets all of the following requirements:
   a. has a valid permanent residency visa;
   b. participates in U.S. Social Security; and
   c. is covered by Workers' Compensation.

Employee means an eligible person who is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the policyholder or an associated company; or
4. a retiree, if listed as eligible in the policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the above conditions.

Employer means the policyholder.

Evidence of Insurability means a signed health and medical history form provided by us, a medical examination, if requested, and any additional information and attending physicians' statements that we may require.

Family Member means a person who is a parent, spouse, child, sibling, domestic partner, grandparent, grandchild, step-child, step-parent, step-sister, step-brother, father-in-law, or mother-in-law of the covered person; or spouses, as applicable, of any of these.

Full-time means working at least the number of hours indicated in the Schedule of Insurance for Full-time employment.

Gender – The use of the male pronoun also includes the female.

Home Office means the principal office of USAble Life in Little Rock, Arkansas.

Hospital means a facility supervised by one or more physicians and operated under state and local laws. It must have 24-hour nursing service by registered graduate nurses. It may specialize in treating alcoholism, drug addiction, chemical dependency, or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged.

Hospital Confined and Hospital Confinement mean staying in a hospital as a registered inpatient for 24 hours a day.

Material Duty or Material Duties mean the sets of tasks or skills required generally by employers from those engaged in an occupation. We will consider one material duty of your regular occupation to be the ability to work for an employer on a full-time basis as defined in the policy.

Noncontributory means the policyholder pays the premium.

Occupation means a group of jobs:

1. in which a common set of tasks is performed; or
2. which are related in terms of similar objectives and methodologies, and which may be related in terms of materials, products, worker actions, or worker characteristics.

Physician means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. This includes a person whom we are required to recognize as a physician by the laws or regulations of the governing jurisdiction. However, neither you nor a family member will be considered a physician.

Plan means the policy and certificates of insurance provided for covered persons.

Plan Administrator means the employer that sponsors the plan for the benefit of its employees and eligible dependents.

Policy means the group policy issued by us to the policyholder that describes the benefits for which you may be eligible.

Policyholder means the entity to which the policy is issued.

Regular Care means you personally visit a physician as often as is medically required to effectively manage and treat your disabling condition(s), according to generally accepted medical standards; and you are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the sickness or injury causing your disability must be given by a physician whose specialty or experience is appropriate.

Regular Occupation means the occupation in which you were working immediately prior to becoming disabled.

Retiree or Retirement means you begin receiving retirement benefits from either:

1. a retirement plan sponsored by your employer, the policyholder, or an associated company, or
2. a government plan.

Sickness means a disease or illness, including pregnancy.

United States of America means the fifty (50) states of the United States and the District of Columbia. It does not include territories of the United States.

Waiting Period is the number of continuous days of service during which you must be an active, full-time employee in a class eligible for insurance before you become eligible for coverage.

We, Us, and Our mean USAble Life.

You and Your mean an employee of the policyholder or an associated company who has met all the eligibility requirements for coverage, and is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the employer, or associated company covered under the policy; or
4. a retiree, if listed as eligible in the group Policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the conditions listed above.

Eligibility and Effective Date Provisions

Eligible Employee

If you are working on a full-time basis for the employer, you are eligible for insurance after completion of the required waiting period, provided you are in a class of employees who are included.

Employee Eligibility Date

If you are working for your employer in an eligible class, the date you are eligible for coverage is the latest of the following dates:

1. the policy effective date;
2. the day after you complete any waiting period shown in the Schedule of Insurance by continuous service with the employer, the policyholder, or an associated company;
3. the date the policy is changed to include your class; or
4. the date you become a member of a class eligible for insurance.

Rehires: If you were insured under this policy and your insurance terminated due to termination of employment or eligibility, and you again become an eligible employee within 12 months, there is no waiting period.

Effective Date of Employee Insurance

You must use forms approved by us when applying for insurance.

1. When your Employer pays 100% of the cost of your coverage under the policy, you will be covered at 12:01 a.m. at your employer's address on your eligibility date.
2. When you and your Employer share the cost of your coverage under the policy or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. at your employer's address on the latest of the following dates:
   a. on your eligibility date, if you enroll for insurance within 31 days after the date you first become eligible for coverage; or
   b. on the first day of the policy month following the date we approve your application if you do not apply for insurance within 31 days after your eligibility date.

Delayed Effective Date

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, it will take effect on the day you return to active work. If your insurance is scheduled to take effect on a non-working day, your active work status will be based on the last working day before the scheduled effective date of your insurance.

Changes in Coverage Provisions

When Coverage Amounts Change (Redetermination Date)

The policy redetermines your amount of insurance on the first of the policy month after a change occurs. If benefits are based on your salary, the policyholder must report updates to all covered person's earnings as they occur. Changes to a covered person's earnings are subject to any proof of insurability requirements of the policy. As of the policy's redetermination date, we use a covered person's salary or earnings on record with us to: (a) set rates; (b) set benefit amounts and limits; and (c) calculate premium payable under the policy.

Delayed Effective Date of Change

You must be actively at work on a full-time basis on the redetermination date. If you are not, your coverage amount will not change until the date you return to active work on a full-time basis. Changes in salary or earnings will not apply to a recurring disability.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

Changes to the Policy

Any increase or decrease in coverage because of a change in the plan of insurance will become effective on the date of the change. The Delayed Effective Date provision will apply to an increase.

Termination Provisions

Termination of Employee Insurance

Your insurance will terminate at 12:00 midnight on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date the policy terminates, or the date a specified benefit terminates;
3. the date you cease to be a member of a class eligible for insurance;
4. the date you cease to be actively at work.

Continuation of Insurance

If you are unable to perform active work for a reason shown below, the policyholder may continue your insurance, except for any Accidental Death and Dismemberment coverage, on a premium-paying basis provided you remain in other respects a member of an eligible class. The continuance cannot be more than the maximum continuance shown below. The employer must act so as not to discriminate unfairly among employees in similar situations.

The maximum continuance for insurance is the longest applicable period described below:

1. three months following the date active work stopped due to lay-off or approved leave of absence, or
2. twelve months following the date active work stopped due to your total disability.

Total Disability for Continuation of Insurance means that you are under the regular care of a physician, and prevented by injury or sickness from performing all of the material duties of your regular occupation.

Claim Provisions

Notice of Loss

Written notice of claim must be given to us at our Home Office within 30 days after a loss occurs or begins, or as soon after the loss as is reasonably possible to do so, but not later than one (1) year from the time notice is required. The notice should identify the covered person and the nature of the loss.

Within 15 days after the date of your notice, we will send you claim forms. The forms must be completed and sent to our Home Office. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.

Proof of Loss

For any loss for which the policy provides periodic payment contingent upon continuing loss, written proof of loss must be given to us within 90 days after the termination of the period for which we are liable. For any other loss covered by the policy, written proof of loss must be given to us within 90 days after the date of such loss. Failure to furnish proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time. Such proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof was otherwise required.

Physical Examination and Autopsy

We have the right to have a physician of our choice examine the covered person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.

Payment of Claims

All benefits payable under this policy will be payable immediately upon receipt of due written proof of such loss.

If included, Dismemberment benefits will be paid to you. Employee Life insurance and Accidental Death benefits will be paid to the person(s) named by you to receive them.

If you failed to name a beneficiary or if no named beneficiary is living at your death, refer to the "Beneficiary" provision below. At our option, up to the maximum allowable by the state laws of the covered person's state of residence may be paid to any person who incurred funeral or other expenses related to the last illness or death of the covered person.

Beneficiary

Your beneficiary will be the person(s) you name in writing to receive any amount of insurance payable due to your death. The beneficiary's name is on record in our Home Office, or in the policyholder's office if the group is self-administered.

You may name or change a beneficiary by giving us written notice at our Home Office (or by giving the policyholder written notice if the group is self-administered) on a form acceptable to us. When we receive the notice, it will be effective on the date made, subject to any payment we may have made before we receive it.

If there is no named beneficiary living at your death, we may pay, at our discretion, any amount due to one of the following classes of survivors: (1) your spouse; (2) your surviving children in equal shares; (3) your mother and/or father; (4) your brother and/or sister; or (5) your estate.

Assignment

You may transfer your rights to name or change the beneficiary to someone else by assignment. An assignment will affect us only if it is in writing on a form acceptable to us, and is received at our Home Office. When we record it, the assignment will take effect as of the date you made it. The assignment will be subject to any action we may have taken before we record it. We take no responsibility for the validity of any assignment.

Claims of Creditors**:** To the extent allowed by law, proceeds will not be subject to any claims of a beneficiary's creditors.

Authority

The policyholder delegates to us and agrees that we have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the policy.

We decide: (a) if a covered person is eligible for this insurance; (b) if a covered person meets the requirements for benefits to be paid; and (c) what benefits are to be paid by the policy. We also interpret how the policy is to be administered. What we pay and the terms for payment are explained in this certificate.

Limit on Legal Action

No action at law or in equity may be brought against the policy until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations has expired, but, in any case, not after three (3) years from the date of loss.

Review Procedure

You must request, in writing, a review of a denial of your claim within 180 days after you receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit written comments, documents, records and other information relating to your claim for benefits.

We will review your claim after receiving your request and send you a notice of our decision within 45 days after we receive your request, or within 90 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant provisions of the policy. We will also advise you of your further appeal rights, if any.

Subrogation and Right of Reimbursement

The plan assumes and is subrogated to your legal rights to recover any payments the plan makes for benefits, when a covered sickness or injury resulted from the action or fault of a third party. The plan's subrogation rights include the right to recover the amount of benefits paid to you.

The plan has the right to recover any and all amounts equal to the plan's payments from:

1. the insurance of the injured party;
2. the person, company (or combination thereof) that caused the sickness or injury, or any insurance company; or
3. any other source, including disability benefit coverage.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The plan's recovery will not be reduced by your negligence, nor by attorney fees and costs you incur.

Priority Right of Reimbursement

Separate and apart from the plan's right of subrogation, the plan shall have first lien and right to reimbursement. This priority right of reimbursement supersedes your right to be made whole from any recovery, whether full or partial. You agree to reimburse the plan 100% first for any and all benefits provided through the plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

1. any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from your own insurance and/or from the third party (or their insurance);
2. any auto or recreational vehicle insurance coverage or benefits including, but not limited to disability benefit coverage; and
3. business and homeowner disability insurance coverage or payments.

The plan may notify those parties of its lien and right to reimbursement without notice to or consent from any covered person.

This priority right of reimbursement will not be reduced by attorney fees and costs you incur.

The plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available disability insurance coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

Notice and Cooperation

You are required to notify us promptly if you are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable us to protect the plan's rights under this section. You are also required to cooperate with us and to execute any documents that we, acting on behalf of the policyholder, deems necessary to protect the plan's rights under this section.

You shall not do anything to hinder, delay, impede or jeopardize the plan's subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the plan to withhold any and all benefits due you under the plan. This is in addition to any and all other rights that the plan has pursuant to the provisions of the plan's subrogation rights and/or priority right of reimbursement.

If the plan has to file suit, or otherwise litigate to enforce its subrogation rights and/or priority right of reimbursement, you are responsible for paying any and all costs, including attorneys' fees, the plan incurs in addition to the amounts recovered through the subrogation rights and/or priority right of reimbursement.

Legal Action and Costs

If a covered person settles any claim or action against any third party, that covered person shall be deemed to have been made whole by the settlement and the plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. The covered person shall hold any such proceeds of settlement or judgment in trust for the benefit of the plan. The plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the covered person in such circumstances.

Additionally, the plan has the right to sue on the covered person's behalf, against any person or entity considered responsible for any condition resulting in benefits paid or to be paid by the plan.

Settlement or Other Compromise

The covered person must notify the plan prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the plan's rights so that the plan may be present and protect its subrogation rights and/or priority right of reimbursement.

The plan's subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against the covered person.

The right of subrogation and the right of reimbursement are based on the plan language in effect at the time of judgment, payment, or settlement.

The plan, or its representative, may enforce the subrogation and priority right of reimbursement.

Alternate Dispute Resolution Procedures

This dispute resolution procedure ("procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all disputes with us. Such disputes include any matters that cause you to be dissatisfied with any aspect of your relationship with us, including any claim, controversy, or potential cause of action you may have against us. Please contact the Dispute Resolution office at (800) 648-0271 if you have any questions about this section of the certificate or to begin the dispute resolution process.

The following terms are applicable to all disputes:

1. This procedure is the exclusive method of resolving any disputes.
2. The procedure can only resolve disputes that are subject to our control.
3. This procedure will be governed by the Employee Retirement Income Security Act of 1974 ("ERISA"); Rules and Regulations for Administration and Enforcement; Claims Procedure (the "Claims Regulation"). That includes the definition of an adverse benefit determination, which is defined as any denial, reduction, termination or failure to provide or make payment for what you believe should be a covered benefit.
4. You may request a form from our Dispute Resolution office to authorize another person to act on your behalf concerning a dispute.
5. We may elect to skip one or more of the steps of this procedure if it is determined that step will not help to resolve the dispute.
6. Any dispute will be resolved in accordance with the terms of this certificate, applicable state or Federal laws and regulations.
7. You must begin the dispute process within 180 days from the date you receive notice of an adverse benefit determination. If you do not initiate the dispute process within that 180 day period, you give up the right to take any action based on that Dispute.

Description of the Procedure

Inquiry

You should contact our Dispute Resolution office to discuss and attempt to resolve any issues regarding a dispute. We hope that this informal process will resolve your questions or concerns.

Appeals

If you are not satisfied with the response to your inquiry, you may submit a written request (an "appeal") to the Office of the Appeals Coordinator, USAble Life, P.O. Box 1650, Little Rock, AR 72203-1650, asking that we reconsider an adverse benefit determination. Please contact the Dispute Resolution office if you have any questions about how to submit an appeal to us. You are not required to use a specific form, but you may request that the Dispute Resolution office send you a blank appeal form to ensure that you provide the information that will be needed to review your appeal.

We will assign a coordinator to review your appeal. The appeal coordinator is an individual with appropriate expertise who is neither the individual who made the adverse benefit determination, nor a subordinate of that individual.

The appeal coordinator may request that you submit additional information concerning your grievance. The appeal coordinator will also consider information submitted by others, including information requested from other USAble Life representatives. The appeal coordinator will have full discretionary authority to make eligibility, benefit or claim determinations and construe the terms of the policy. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the policy is not governed by ERISA.

We will make a decision within 60 days after receiving your appeal concerning a claim determination.

The appeal coordinator will send you a written decision concerning your appeal. The appeal coordinator's decision will include: a statement of the coordinator's understanding of your appeal; a statement explaining the basis of the decision; and a list of the documents or information upon which that decision was based. We will send you a copy of the listed documents, without charge, if you make a written request for such documents.

Post Appeal Procedure

If you are still not satisfied after completing the appeal procedure, you have the right to bring a civil action against us to obtain the remedies available pursuant to Sec. 502(a) of ERISA (an "ERISA Action") after completing the mandatory appeal process. Those ERISA remedies will apply to this policy even if your plan is not otherwise governed by ERISA. If you agree to arbitrate a dispute, we agree to suspend (or toll) any time periods affecting your right to bring an ERISA Action against us related to that dispute, until the arbitration has been completed.

You may request that the dispute be submitted for resolution by arbitration. That arbitration request must be submitted, in writing, to USAble Life's General Counsel within sixty (60) days after you receive the appeal coordinator's decision.

The dispute will be submitted to arbitration in accordance with the rules of the American Arbitration Association, unless we both agree to use an alternative dispute resolution administrator or procedure. The arbitration will be conducted before a single arbitrator.

We will pay the filing fee charged by the administrator and the arbitrator. You will be solely responsible for any other costs that you incur to participate in the arbitration process, including your attorney's fees. The filing fee and arbitrator's fees may be reallocated as part of an arbitration award, in whole or in part, at the discretion of the arbitrator.

The arbitration will be conducted in a location where it is reasonably convenient for you to participate. If we cannot agree concerning a convenient location, the administrator or arbitrator, if appointed, shall have the discretion to decide where the arbitration will be conducted.

The arbitrator: (a) shall consider the dispute individually and shall not certify or consider multiple disputes as part of a class action; (b) shall be required to issue a reasoned written decision explaining the basis of his or her decision and the manner of calculating any award; (c) shall limit his or her decision to deciding if our adverse benefit decision was arbitrary or capricious based on ERISA standards; (d) may not award punitive, extra-contractual, treble or exemplary damages unless permitted to do so by applicable statutes or regulations; (e) may not vary or disregard the terms of the policy; and (f) shall be bound by controlling law; when issuing a decision concerning the dispute.

The arbitrator shall limit discovery to the extent possible consistent with the objective of completing the arbitration in a fair, prompt, and cost effective manner. Emergency relief such as injunctive relief may be awarded by the arbitrator.

Contact Information

General Counsel
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: [(800) 648-0271]
Email: AppealCoordinator@usablelife.com

Office of the Dispute Resolution Coordinator
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
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General Provisions

Entire Contract

This certificate is furnished in accordance with and subject to the terms of the policy. The entire contract consists of the policy, which includes the application, any amendments and addenda; this certificate; your enrollment form, if required; and any riders or endorsements. No change in the policy will be effective until approved by one of our officers. This approval can only be in writing and must be noted on or attached to the policy. No agent has authority to change the policy or certificate or to waive any of their provisions.

Any statement made by you or the policyholder is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about you or the policyholder's plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

Incontestability

Unless the premiums have not been paid, the validity of the policy cannot be contested after it has been in force for two years.

Any statement made by the policyholder or a covered person will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the covered person or the beneficiary.

No statement, except fraudulent misstatement, made by a covered person about insurability will be used to deny a claim for a loss incurred or disability starting after coverage has been in effect for two years.

No claim for loss starting two or more years after the covered person's effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Agency

Neither the policyholder, any employer, any associated company, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

Unpaid Premium

We may deduct any unpaid premium then due from the payment of a claim under this certificate.

Refund of Premium

On the death of the covered person, proceeds payable hereunder shall include the amount of unearned premium paid beyond the end of the policy month in which death occurred. Payment shall be made in one lump sum no later than 30 days after proof of the covered person's death has been furnished to us.

Conformity with State Statutes

If the provisions of this certificate do not conform with the laws of the state in which you reside on the certificate effective date, they are hereby amended to conform with the minimum requirements of the statutes of that state.

Policy Management

Efficient management of the policy requires the joint efforts of the policyholder, USAble Life, and each covered person. Each party has certain duties to bring about the effective administration of the policy.

Duties of the Policyholder: The policyholder's primary duties under the policy are listed below.

1. Give us prompt, written notice of any change in business of the policyholder and employer. This includes, but is not limited to: (a) the type of business; (b) addition or deletion of an associated company; or (c) financial status due to bankruptcy; merger; acquisition; or dissolution.
2. Give us pertinent records for all covered persons. This includes, but is not limited to: (a) hire dates; (b) eligibility dates; (c) salaries; (d) occupations; and (e) birth dates. Give us updates of such records as needed.
3. Give us prompt notice of a covered person's disability. This notice should be given as soon as possible after the date of injury or start of sickness. The most effective time for such notice is when the covered person has not been able to perform active work for 30 days.
4. Give us occupational data for all disabled covered persons. This includes, but is not limited to: (a) job descriptions and analyses; and (b) environmental factors.

Duties of Covered Persons and Beneficiaries: Your and your beneficiary's primary duties under the policy are listed below:

1. Give notice and proof of loss as soon as possible after the date of your injury or sickness, or the date of your death, or the death of a covered dependent, if applicable.
2. Give a complete account of the details of your injury or sickness or the death on a form approved by us.
3. Provide any other official documents to review the loss such as a certified death certificate, investigating officer's report, or medical records.
4. Allow release of medical and income data needed to adjudicate your claim.
5. Provide evidence of the regular care of a physician, if necessary.
6. Promptly report to us any changes in your status such as your address or telephone number, or if you return to work or are no longer disabled.
7. If benefits are overpaid, reimburse such overpayment within 60 days of the date benefits were overpaid.
8. Provide proof of your earnings for the period prior to a loss.

Fraud

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the policy and recovery of any amounts we have paid.

Employee Term Life Insurance

Death Benefit

We will pay your beneficiary the amount of insurance in force on the date of death, as shown in the Schedule of Insurance, when we receive all required proof of loss, including written proof of your death acceptable to us and a completed claim form.

Conversion Privilege for Life Insurance

Conversion upon Termination of Employment or Eligibility

For Employees
You may convert all or part of your life insurance to an individual policy of life insurance, other than Term,

1. if all or part of it stops for any reason; unless
2. it stops because you did not pay any required premiums.

The amount you may apply for may not be more than:

1. the life amount then in force; or
2. that part of the life amount which has stopped, whichever is less.

Accidental death and dismemberment, disability or any other supplemental coverage for which you are eligible under this policy may not be converted.

Conversion upon Termination or Amendment of Group Policy

Any covered person may convert a limited amount of life insurance if he has been continuously insured under the policy for at least five (5) years and his insurance ends due to termination or amendment of the policy.

The amount you may convert in this case is the smaller of the following:

1. the amount of life insurance which terminates, less the amount you became eligible for under any group policy within 31 days after this insurance terminated; or
2. $10,000.

Conversion Coverage

Any covered person may convert his life insurance to any policy we are issuing for the purpose of conversions other than Term. The conversion policy will not have disability or other supplementary benefits. No evidence of insurability will be required. The premium will be based on the amount and the form of the conversion policy, and on the covered person's class of risk and age on the date the conversion takes effect.

A conversion policy is in lieu of all other benefits under this policy. If you qualify for the Extended Insurance Benefit, any conversion policy issued will be canceled. Premiums paid for the converted policy will be returned.

The conversion policy will take effect on the 32nd day after the insurance terminates.

Notice and Application Required

Written application and the first premium payment for the conversion policy must be received in our Home Office within 31 days after the covered person's insurance terminates. If you are not given notice of the right to convert by the 16th day of the 31 day conversion period, you will have an additional period in which to apply for conversion. The additional period will end 15 days after you are given notice, but not more than 61 days after the date the insurance under the policy ended.

Nothing in the policy will continue coverage for more than 31 days following the date coverage ends under the policy. Written notice, contained in this certificate of insurance and given to you at any time, or mailed by the policyholder to your last known address will be considered sufficient written notice to you. It is the responsibility of the policyholder to give such notice to you.

Conversion Period Death Benefit

If the covered person dies within the 31 days allowed for making application to convert, we will pay the amount he was entitled to convert. We will do this whether or not application was made.

Accidental Death & Dismemberment Insurance

This section applies to the Basic Accidental Death & Dismemberment (AD&D) Benefit.

For Basic AD&D, you are the only covered person under this benefit.

If a covered person suffers a loss described below, we will pay the amount of insurance that applies. You or your beneficiary must give us proof that:

1. injury occurred while the insurance was in force under this section;
2. loss occurred within 365 days after the injury; and
3. loss was due to injury independent of all other causes.

Amount of Insurance

If a covered person suffers a specified loss, we will pay the benefit set opposite such loss; provided, however, that if the covered person sustains more than one such loss as the result of any one accident, we will pay only the one largest amount to which the covered person is entitled. In paying the benefit, we will consider only losses sustained while insured under this benefit.

Loss of Life .....100% of the AD&D Amount

Loss of Two or More Members.....100% of the AD&D Amount

Loss of One Member.....50% of the AD&D Amount

Loss of Thumb and Index Finger
of the Same Hand .....25% of the AD&D Amount

Member means hand, foot, sight, speech, or hearing.

Loss of sight means total and irrecoverable loss of sight.

Loss of hands or feet means total and irrecoverable loss due to severance at or above the wrist or ankle, unless the state in which the policy is issued defines the loss differently.

Loss of Thumb and Index Finger means total and irrecoverable loss at the proximal phalanx.

Loss of speech means a total and irrecoverable loss of audible communication.

Loss of hearing means permanent total deafness in both ears such that it cannot be corrected to any functional degree by any aid or device.

Exclusions

We will not pay a benefit for a loss caused directly or indirectly by:

1. disease, bodily or mental infirmity, or infection (except bacterial infection of a visible injury);
2. war or any act of war, or while serving in the armed forces of any country or international authority;
3. suicide or intentional, self-inflicted injury, whether sane or insane;
4. your active participation in a riot or insurrection;
5. your voluntary commission of, or attempting to commit, an assault or felony; or participating in an illegal occupation;
6. your voluntary use of any drug, hallucinogen, controlled substance, or narcotic unless taken as prescribed by a physician;

7. travel or flight in, or descent from, any aircraft unless as a fare paying passenger on a commercial airline flying between established airports on: (a) a scheduled route, or (b) a charter flight;
8. your being intoxicated as defined by the laws of the jurisdiction in which the accident occurred. Conviction is not necessary for a determination of being intoxicated.

Participation in a riot shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.

Riot shall include all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

War means declared or undeclared war or a conflict involving the armed forces of any country, group of countries, governments, or international organization.

Group Life Accelerated Benefit

This section applies to the Basic Life Insurance Benefit only.

Notice of Possible Tax Consequences

Please be advised that receipt of the accelerated benefits may be taxable. Any person who receives accelerated benefits should consult his personal tax advisor.

The receipt of accelerated benefit payments may adversely affect the covered person's eligibility for Medicaid or other government benefits or entitlements.

Definitions

"Terminal Illness" means a medical condition:

1. which is expected to result in the covered person's death within 12 months; and
2. from which the covered person is not expected to recover.

Eligibility

All covered employees under age 70 who are insured for a minimum of $10,000 of life insurance under the policy are eligible.

A covered employee is eligible for the accelerated benefit only if he becomes and remains insured for life insurance under the policy.

Accelerated Benefit

The accelerated benefit is an advance payment to the covered person who:

1. is terminally ill; and
2. elects to receive part of his life insurance benefit payable under the group policy, subject to the maximum benefit amounts stated on the Schedule of Insurance.

We will pay an accelerated benefit to you when we receive the following:

1. a written request for payment of the accelerated benefit; and
2. proof that the covered person is terminally ill and his illness is expected to result in his death within 12 months.

The accelerated benefit will be paid only once for each eligible covered person, and in one lump sum to you before death occurs.

Cost of Providing the Accelerated Benefit

There is no cost associated with providing the accelerated benefit.

Amount of Accelerated Benefit

The maximum accelerated benefit will be the lesser of:

1. 75% of the covered person's life insurance amount; or
2. $250,000.

If the covered person's life insurance amount is scheduled for a reduction within 12 months after the date you request the payment of the accelerated benefit, the maximum accelerated benefit will be based on the reduced amount.

Irrevocable Beneficiary

For the purpose of the Accelerated Benefit provision, an irrevocable beneficiary is a named beneficiary whose rights to the employee's life insurance proceeds are vested and whose rights cannot be cancelled by the employee unless the irrevocable beneficiary consents.

Conditions and Requirements for Payment of the Accelerated Benefit

You must request payment of an accelerated benefit in writing.

Proof that the covered person is terminally ill must be provided to us. The proof must be certified by a licensed physician and in a form that is satisfactory to us. We are not obligated to ask for any proof. Any delay in submitting proof will not cause a request to be denied if the proof is given to us as soon as reasonably possible.

After receipt of such proof, we may require the covered person to be examined by a licensed physician of our choice, at our expense. If there is a disagreement between the two physicians, we may require the covered person to be examined by another licensed physician of our choice, at our expense. The decision of the third physician will be final.

Effect of Payment of an Accelerated Benefit on Policy Provisions

The covered person's amount of life insurance under the policy will be reduced by the amount of any accelerated benefit that has been previously paid.

The following will be based on the reduced life insurance amount:

1. the amount of life insurance payable to the beneficiary when the covered person dies;
2. the amount of life insurance the covered person can convert under the policy; and
3. the premiums payable for the covered person's life insurance under the policy after an accelerated benefit is paid to you, if such premiums are not waived.

The payment of an accelerated benefit will not affect the amount of the covered person's Accidental Death and Dismemberment Benefits under the group policy, if any.

Exclusions

We will not pay an accelerated benefit if:

1. the covered person has made an absolute assignment of his life insurance under the policy and we do not receive written consent by the absolute assignee;
2. all or part of the covered person's life insurance under the group policy is to be paid to his children or former spouse as part of a court approved divorce agreement;
3. the covered person has made an irrevocable beneficiary designation of his life insurance under the policy and we do not receive written consent by the irrevocable beneficiary; or
4. the terminal illness is a result of intentional self-inflicted injury or attempted suicide, committed while sane or insane.

Date Insurance Ends under this Benefit

A covered person's insurance under this benefit will end at the earliest of:

1. the date the accelerated benefit is paid to you on the covered person's behalf;
2. the date the covered person's life insurance ends under the policy; or
3. the policy anniversary on which the covered person is age 70.

Important Notice

The following information is provided to assist you in answering any questions you might have:

Soliciting Agent
The name, address and telephone number of our soliciting agent is available to you, if needed, by calling our Customer Service Department at [(800) 370-5856].

USAble Life

USAble Life
P. O. Box 1650
Little Rock, AR 72203-1650
Toll Free [(800) 370-5856]

If we fail to provide you with reasonable and adequate service, you may contact:

Arkansas Insurance Department

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Phone (501) 371-2640 or
Toll Free 1-800-852-5494

We appreciate the opportunity to serve your insurance needs.

ERISA Information

Plan Sponsorship and Administration

The plan was established by the actions of your employer, which continues to act as Plan Sponsor and Plan Administrator. Your employer, as Plan Administrator, performs the functions of distributing Plan notices and information to employees and other Plan participants, coordinates employees' and eligible dependents' enrollment in the Plan, and transmits Plan premium payments.

ERISA Rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.
4. Neither your employer, nor any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
5. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
6. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, provided that you have first followed the Plan's designated appeals procedure before bringing suit.
7. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees.
8. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
9. If you have any questions about your Plan, you should contact the Plan Administrator.
10. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

USAble Life

[320 W. Capitol] • P.O. Box 1650 • Little Rock, AR 72203-1650
[(501) 375-7200 • (800) 648-0271]

CERTIFICATE OF INSURANCE

Retiree Group Term Life

Policyholder: SIMMONS FIRST NATIONAL BANK

Class: 004 - GRANDFATHERED RETIREES

State of Residence: ARKANSAS

This is to certify that USAble Life has issued and delivered the Group Term Life Insurance Policy to the Policyholder.

The policy insures the employees and their dependents, if elected, of the policyholder who:

1. are eligible for the insurance;
2. become insured; and
3. continue to be insured;

according to the terms of the policy.

The terms of the policy that affect your insurance are contained in the following pages.

This Certificate of Insurance is a part of the policy. This certificate replaces any other that USAble Life may have issued to the policyholder to give to you under the Group Insurance Policy specified herein.

Signed for USAble Life:

James L. Tourse — Secretary

Jason Ram — President

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Schedule of Insurance

Policyholder: SIMMONS FIRST NATIONAL BANK

Group Policy Number: 50001328

Policy Effective Date: September 1, 2010*
*This certificate replaces any certificate issued before the date shown.

Eligible Class: Class 004 - GRANDFATHERED RETIREES

Benefits amounts for eligible employees shall be determined in accordance with the following schedule:

Benefit	Benefit Amount
Retiree Life	The amount of coverage on file with the employer.

Reductions, Terminations, and Special Provisions

Retiree Life	Benefits do not reduce or terminate.

Definitions

The terms listed, if used, will have these meanings.

Accident or Injury mean accidental bodily injury sustained by the covered person while insured under the policy which is the direct cause of the loss, independent of disease or bodily infirmity or any other cause.

Beneficiary means the person or entity you choose to receive your amount of insurance at your death.

Covered Person means an eligible retiree whose insurance has become and remains effective under all the conditions and provisions of the policy. Covered persons do not include contract, temporary, seasonal, or part-time workers.

Eligible Class means a class of persons eligible for insurance under the policy. This class is based on employment or membership in a group.

Eligible Persons means a person who:

1. is a citizen of the United States of America (U.S.) or Canada, who either:
   a. resides in the U.S. or Canada; or
   b. is stationed outside the U.S. or Canada for a period of less than 6 months; or
2. is a foreign national residing in the U.S. and meets all of the following requirements:
   a. has a valid permanent residency visa;
   b. participates in U.S. Social Security; and
   c. is covered by Workers' Compensation.

Employee means an eligible person who is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the policyholder or an associated company; or
4. a retiree, if listed as eligible in the policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the above conditions.

Employer means the policyholder.

Family Member means a person who is a parent, spouse, child, sibling, domestic partner, grandparent, grandchild, step-child, step-parent, step-sister, step-brother, father-in-law, or mother-in-law of the covered person; or spouses, as applicable, of any of these.

Full-time means working at least the number of hours indicated in the Schedule of Insurance for Full-time employment.

Gender – The use of the male pronoun also includes the female.

Home Office means the principal office of USAble Life in Little Rock, Arkansas.

Physician means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. This includes a person whom we are required to recognize as a physician by the laws or regulations of the governing jurisdiction. However, neither you nor a family member will be considered a physician.

Plan means the policy and certificates of insurance provided for covered persons.

Plan Administrator means the employer that sponsors the plan for the benefit of its employees and eligible dependents.

Policy means the group policy issued by us to the policyholder that describes the benefits for which you may be eligible.

Policyholder means the entity to which the policy is issued.

Regular Care means you personally visit a physician as often as is medically required to effectively manage and treat your disabling condition(s), according to generally accepted medical standards; and you are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the sickness or injury causing your disability must be given by a physician whose specialty or experience is appropriate.

Retiree or Retirement means you begin receiving retirement benefits from either:

1. a retirement plan sponsored by your employer, the policyholder, or an associated company, or
2. a government plan.

Sickness means a disease or illness, including pregnancy.

United States of America means the fifty (50) states of the United States and the District of Columbia. It does not include territories of the United States.

Waiting Period is the number of continuous days of service during which you must be an active, full-time employee in a class eligible for insurance before you become eligible for coverage.

We, Us, and Our mean USAble Life.

You and Your mean an employee of the policyholder or an associated company who has met all the eligibility requirements for coverage, and is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the employer, or associated company covered under the policy; or
4. a retiree, if listed as eligible in the group Policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the conditions listed above.

Eligibility and Effective Date Provisions

Eligible Retiree

If you are a retiree as defined in the Schedule of Insurance, you are eligible for insurance.

Retiree Eligibility Date

The date you are eligible for retiree coverage is the latest of the following dates:

1. the policy effective date;
2. the date the policy is changed to include your class; or
3. the date you become a member of a class eligible for insurance.

Effective Date of Retiree Insurance

You will be covered at 12:01 a.m. at your employer's address on your eligibility date.

Termination Provisions

Termination of Retiree Insurance

Your insurance will terminate at 12:00 midnight on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date the policy terminates, or the date a specified benefit terminates; or
3. the date you cease to be a member of a class eligible for insurance.

Claim Provisions

Notice of Loss

Written notice of claim must be given to us at our Home Office within 30 days after a loss occurs or begins, or as soon after the loss as is reasonably possible to do so, but not later than one (1) year from the time notice is required. The notice should identify the covered person and the nature of the loss.

Within 15 days after the date of your notice, we will send you claim forms. The forms must be completed and sent to our Home Office. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.

Proof of Loss

For any loss for which the policy provides periodic payment contingent upon continuing loss, written proof of loss must be given to us within 90 days after the termination of the period for which we are liable. For any other loss covered by the policy, written proof of loss must be given to us within 90 days after the date of such loss. Failure to furnish proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time. Such proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof was otherwise required.

Physical Examination and Autopsy

We have the right to have a physician of our choice examine the covered person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.

Payment of Claims

All benefits payable under this policy will be payable immediately upon receipt of due written proof of such loss.

If included, benefits will be paid to you. Employee Life insurance benefits will be paid to the person(s) named by you to receive them.

If you failed to name a beneficiary or if no named beneficiary is living at your death, refer to the "Beneficiary" provision below. At our option, up to the maximum allowable by the state laws of the covered person's state of residence may be paid to any person who incurred funeral or other expenses related to the last illness or death of the covered person.

Beneficiary

Your beneficiary will be the person(s) you name in writing to receive any amount of insurance payable due to your death. The beneficiary's name is on record in our Home Office, or in the policyholder's office if the group is self-administered.

You may name or change a beneficiary by giving us written notice at our Home Office (or by giving the policyholder written notice if the group is self-administered) on a form acceptable to us. When we receive the notice, it will be effective on the date made, subject to any payment we may have made before we receive it.

If there is no named beneficiary living at your death, we may pay, at our discretion, any amount due to one of the following classes of survivors: (1) your spouse; (2) your surviving children in equal shares; (3) your mother and/or father; (4) your brother and/or sister; or (5) your estate.

Assignment

You may transfer your rights to name or change the beneficiary to someone else by assignment. An assignment will affect us only if it is in writing on a form acceptable to us, and is received at our Home Office. When we record it, the assignment will take effect as of the date you made it. The assignment will be subject to any action we may have taken before we record it. We take no responsibility for the validity of any assignment.

Claims of Creditors**:** To the extent allowed by law, proceeds will not be subject to any claims of a beneficiary's creditors.

Authority

The policyholder delegates to us and agrees that we have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the policy.

We decide: (a) if a covered person is eligible for this insurance; (b) if a covered person meets the requirements for benefits to be paid; and (c) what benefits are to be paid by the policy. We also interpret how the policy is to be administered. What we pay and the terms for payment are explained in this certificate.

Limit on Legal Action

No action at law or in equity may be brought against the policy until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations has expired, but, in any case, not after three (3) years from the date of loss.

Review Procedure

You must request, in writing, a review of a denial of your claim within 180 days after you receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit written comments, documents, records and other information relating to your claim for benefits.

We will review your claim after receiving your request and send you a notice of our decision within 45 days after we receive your request, or within 90 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant provisions of the policy. We will also advise you of your further appeal rights, if any.

Subrogation and Right of Reimbursement

The plan assumes and is subrogated to your legal rights to recover any payments the plan makes for benefits, when a covered sickness or injury resulted from the action or fault of a third party. The plan's subrogation rights include the right to recover the amount of benefits paid to you.

The plan has the right to recover any and all amounts equal to the plan's payments from:

1. the insurance of the injured party;
2. the person, company (or combination thereof) that caused the sickness or injury, or any insurance company; or
3. any other source, including disability benefit coverage.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The plan's recovery will not be reduced by your negligence, nor by attorney fees and costs you incur.

Priority Right of Reimbursement

Separate and apart from the plan's right of subrogation, the plan shall have first lien and right to reimbursement. This priority right of reimbursement supersedes your right to be made whole from any recovery, whether full or partial. You agree to reimburse the plan 100% first for any and all benefits provided through the plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

1. any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from your own insurance and/or from the third party (or their insurance);
2. any auto or recreational vehicle insurance coverage or benefits including, but not limited to disability benefit coverage; and
3. business and homeowner disability insurance coverage or payments.

The plan may notify those parties of its lien and right to reimbursement without notice to or consent from any covered person.

This priority right of reimbursement will not be reduced by attorney fees and costs you incur.

The plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available disability insurance coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

Notice and Cooperation

You are required to notify us promptly if you are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable us to protect the plan's rights under this section. You are also required to cooperate with us and to execute any documents that we, acting on behalf of the policyholder, deems necessary to protect the plan's rights under this section.

You shall not do anything to hinder, delay, impede or jeopardize the plan's subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the plan to withhold any and all benefits due you under the plan. This is in addition to any and all other rights that the plan has pursuant to the provisions of the plan's subrogation rights and/or priority right of reimbursement.

If the plan has to file suit, or otherwise litigate to enforce its subrogation rights and/or priority right of reimbursement, you are responsible for paying any and all costs, including attorneys' fees, the plan incurs in addition to the amounts recovered through the subrogation rights and/or priority right of reimbursement.

Legal Action and Costs

If a covered person settles any claim or action against any third party, that covered person shall be deemed to have been made whole by the settlement and the plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. The covered person shall hold any such proceeds of settlement or judgment in trust for the benefit of the plan. The plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the covered person in such circumstances.

Additionally, the plan has the right to sue on the covered person's behalf, against any person or entity considered responsible for any condition resulting in benefits paid or to be paid by the plan.

Settlement or Other Compromise

The covered person must notify the plan prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the plan's rights so that the plan may be present and protect its subrogation rights and/or priority right of reimbursement.

The plan's subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against the covered person.

The right of subrogation and the right of reimbursement are based on the plan language in effect at the time of judgment, payment, or settlement.

The plan, or its representative, may enforce the subrogation and priority right of reimbursement.

Alternate Dispute Resolution Procedures

This dispute resolution procedure ("procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all disputes with us. Such disputes include any matters that cause you to be dissatisfied with any aspect of your relationship with us, including any claim, controversy, or potential cause of action you may have against us. Please contact the Dispute Resolution office at (800) 648-0271 if you have any questions about this section of the certificate or to begin the dispute resolution process.

The following terms are applicable to all disputes:

1. This procedure is the exclusive method of resolving any disputes.
2. The procedure can only resolve disputes that are subject to our control.
3. This procedure will be governed by the Employee Retirement Income Security Act of 1974 ("ERISA"); Rules and Regulations for Administration and Enforcement; Claims Procedure (the "Claims Regulation"). That includes the definition of an adverse benefit determination, which is defined as any denial, reduction, termination or failure to provide or make payment for what you believe should be a covered benefit.
4. You may request a form from our Dispute Resolution office to authorize another person to act on your behalf concerning a dispute.
5. We may elect to skip one or more of the steps of this procedure if it is determined that step will not help to resolve the dispute.
6. Any dispute will be resolved in accordance with the terms of this certificate, applicable state or Federal laws and regulations.
7. You must begin the dispute process within 180 days from the date you receive notice of an adverse benefit determination. If you do not initiate the dispute process within that 180 day period, you give up the right to take any action based on that Dispute.

Description of the Procedure

Inquiry

You should contact our Dispute Resolution office to discuss and attempt to resolve any issues regarding a dispute. We hope that this informal process will resolve your questions or concerns.

Appeals

If you are not satisfied with the response to your inquiry, you may submit a written request (an "appeal") to the Office of the Appeals Coordinator, USAble Life, P.O. Box 1650, Little Rock, AR 72203-1650, asking that we reconsider an adverse benefit determination. Please contact the Dispute Resolution office if you have any questions about how to submit an appeal to us. You are not required to use a specific form, but you may request that the Dispute Resolution office send you a blank appeal form to ensure that you provide the information that will be needed to review your appeal.

We will assign a coordinator to review your appeal. The appeal coordinator is an individual with appropriate expertise who is neither the individual who made the adverse benefit determination, nor a subordinate of that individual.

The appeal coordinator may request that you submit additional information concerning your grievance. The appeal coordinator will also consider information submitted by others, including information requested from other USAble Life representatives. The appeal coordinator will have full discretionary authority to make eligibility, benefit or claim determinations and construe the terms of the policy. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the policy is not governed by ERISA.

We will make a decision within 60 days after receiving your appeal concerning a claim determination.

The appeal coordinator will send you a written decision concerning your appeal. The appeal coordinator's decision will include: a statement of the coordinator's understanding of your appeal; a statement explaining the basis of the decision; and a list of the documents or information upon which that decision was based. We will send you a copy of the listed documents, without charge, if you make a written request for such documents.

Post Appeal Procedure

If you are still not satisfied after completing the appeal procedure, you have the right to bring a civil action against us to obtain the remedies available pursuant to Sec. 502(a) of ERISA (an "ERISA Action") after completing the mandatory appeal process. Those ERISA remedies will apply to this policy even if your plan is not otherwise governed by ERISA. If you agree to arbitrate a dispute, we agree to suspend (or toll) any time periods affecting your right to bring an ERISA Action against us related to that dispute, until the arbitration has been completed.

You may request that the dispute be submitted for resolution by arbitration. That arbitration request must be submitted, in writing, to USAble Life's General Counsel within sixty (60) days after you receive the appeal coordinator's decision.

The dispute will be submitted to arbitration in accordance with the rules of the American Arbitration Association, unless we both agree to use an alternative dispute resolution administrator or procedure. The arbitration will be conducted before a single arbitrator.

We will pay the filing fee charged by the administrator and the arbitrator. You will be solely responsible for any other costs that you incur to participate in the arbitration process, including your attorney's fees. The filing fee and arbitrator's fees may be reallocated as part of an arbitration award, in whole or in part, at the discretion of the arbitrator.

The arbitration will be conducted in a location where it is reasonably convenient for you to participate. If we cannot agree concerning a convenient location, the administrator or arbitrator, if appointed, shall have the discretion to decide where the arbitration will be conducted.

The arbitrator: (a) shall consider the dispute individually and shall not certify or consider multiple disputes as part of a class action; (b) shall be required to issue a reasoned written decision explaining the basis of his or her decision and the manner of calculating any award; (c) shall limit his or her decision to deciding if our adverse benefit decision was arbitrary or capricious based on ERISA standards; (d) may not award punitive, extra-contractual, treble or exemplary damages unless permitted to do so by applicable statutes or regulations; (e) may not vary or disregard the terms of the policy; and (f) shall be bound by controlling law; when issuing a decision concerning the dispute.

The arbitrator shall limit discovery to the extent possible consistent with the objective of completing the arbitration in a fair, prompt, and cost effective manner. Emergency relief such as injunctive relief may be awarded by the arbitrator.

Contact Information

General Counsel
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: [(800) 648-0271]
Email: AppealCoordinator@usablelife.com

Office of the Dispute Resolution Coordinator
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: [(800) 648-0271]
Email: AppealCoordinator@usablelife.com

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General Provisions

Entire Contract

This certificate is furnished in accordance with and subject to the terms of the policy. The entire contract consists of the policy, which includes the application, any amendments and addenda; this certificate; your enrollment form, if required; and any riders or endorsements. No change in the policy will be effective until approved by one of our officers. This approval can only be in writing and must be noted on or attached to the policy. No agent has authority to change the policy or certificate or to waive any of their provisions.

Any statement made by you or the policyholder is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about you or the policyholder's plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

Incontestability

Unless the premiums have not been paid, the validity of the policy cannot be contested after it has been in force for two years.

Any statement made by the policyholder or a covered person will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the covered person or the beneficiary.

No statement, except fraudulent misstatement, made by a covered person about insurability will be used to deny a claim for a loss incurred or disability starting after coverage has been in effect for two years.

No claim for loss starting two or more years after the covered person's effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Agency

Neither the policyholder, any employer, any associated company, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

Unpaid Premium

We may deduct any unpaid premium then due from the payment of a claim under this certificate.

Refund of Premium

On the death of the covered person, proceeds payable hereunder shall include the amount of unearned premium paid beyond the end of the policy month in which death occurred. Payment shall be made in one lump sum no later than 30 days after proof of the covered person's death has been furnished to us.

Conformity with State Statutes

If the provisions of this certificate do not conform with the laws of the state in which you reside on the certificate effective date, they are hereby amended to conform with the minimum requirements of the statutes of that state.

Policy Management

Efficient management of the policy requires the joint efforts of the policyholder, USAble Life, and each covered person. Each party has certain duties to bring about the effective administration of the policy.

Duties of the Policyholder: The policyholder's primary duties under the policy are listed below.

1. Give us prompt, written notice of any change in business of the policyholder and employer. This includes, but is not limited to: (a) the type of business; (b) addition or deletion of an associated company; or (c) financial status due to bankruptcy; merger; acquisition; or dissolution.
2. Give us pertinent records for all covered persons. This includes, but is not limited to: (a) hire dates; (b) eligibility dates; (c) salaries; (d) occupations; and (e) birth dates. Give us updates of such records as needed.
3. Give us prompt notice of a covered person's disability. This notice should be given as soon as possible after the date of injury or start of sickness. The most effective time for such notice is when the covered person has not been able to perform active work for 30 days.
4. Give us occupational data for all disabled covered persons. This includes, but is not limited to: (a) job descriptions and analyses; and (b) environmental factors.

Duties of Covered Persons and Beneficiaries: Your and your beneficiary's primary duties under the policy are listed below:

1. Give notice and proof of loss as soon as possible after the date of your injury or sickness, or the date of your death, or the death of a covered dependent, if applicable.
2. Give a complete account of the details of your injury or sickness or the death on a form approved by us.
3. Provide any other official documents to review the loss such as a certified death certificate, investigating officer's report, or medical records.
4. Allow release of medical and income data needed to adjudicate your claim.
5. Provide evidence of the regular care of a physician, if necessary.
6. Promptly report to us any changes in your status such as your address or telephone number, or if you return to work or are no longer disabled.
7. If benefits are overpaid, reimburse such overpayment within 60 days of the date benefits were overpaid.
8. Provide proof of your earnings for the period prior to a loss.

Fraud

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the policy and recovery of any amounts we have paid.

Retiree Term Life Insurance

Death Benefit

We will pay your beneficiary the amount of insurance in force on the date of death, as shown in the Schedule of Insurance, when we receive all required proof of loss, including written proof of your death acceptable to us and a completed claim form.

Conversion Privilege for Life Insurance

Conversion upon Termination of Employment or Eligibility

For Employees
You may convert all or part of your life insurance to an individual policy of life insurance, other than Term,

1. if all or part of it stops for any reason; unless
2. it stops because you did not pay any required premiums.

The amount you may apply for may not be more than:

1. the life amount then in force; or
2. that part of the life amount which has stopped, whichever is less.

Accidental death and dismemberment, disability or any other supplemental coverage for which you are eligible under this policy may not be converted.

Conversion upon Termination or Amendment of Group Policy

Any covered person may convert a limited amount of life insurance if he has been continuously insured under the policy for at least five (5) years and his insurance ends due to termination or amendment of the policy.

The amount you may convert in this case is the smaller of the following:

1. the amount of life insurance which terminates, less the amount you became eligible for under any group policy within 31 days after this insurance terminated; or
2. $10,000.

Conversion Coverage

Any covered person may convert his life insurance to any policy we are issuing for the purpose of conversions other than Term. The conversion policy will not have disability or other supplementary benefits. No evidence of insurability will be required. The premium will be based on the amount and the form of the conversion policy, and on the covered person's class of risk and age on the date the conversion takes effect.

A conversion policy is in lieu of all other benefits under this policy. If you qualify for the Extended Insurance Benefit, any conversion policy issued will be canceled. Premiums paid for the converted policy will be returned.

The conversion policy will take effect on the 32nd day after the insurance terminates.

Notice and Application Required

Written application and the first premium payment for the conversion policy must be received in our Home Office within 31 days after the covered person's insurance terminates. If you are not given notice of the right to convert by the 16th day of the 31 day conversion period, you will have an additional period in which to apply for conversion. The additional period will end 15 days after you are given notice, but not more than 61 days after the date the insurance under the policy ended.

Nothing in the policy will continue coverage for more than 31 days following the date coverage ends under the policy. Written notice, contained in this certificate of insurance and given to you at any time, or mailed by the policyholder to your last known address will be considered sufficient written notice to you. It is the responsibility of the policyholder to give such notice to you.

Conversion Period Death Benefit

If the covered person dies within the 31 days allowed for making application to convert, we will pay the amount he was entitled to convert. We will do this whether or not application was made.

Group Life Accelerated Benefit

This section applies to the Basic Life Insurance Benefit only.

Notice of Possible Tax Consequences

Please be advised that receipt of the accelerated benefits may be taxable. Any person who receives accelerated benefits should consult his personal tax advisor.

The receipt of accelerated benefit payments may adversely affect the covered person's eligibility for Medicaid or other government benefits or entitlements.

Definitions

"Terminal Illness" means a medical condition:

1. which is expected to result in the covered person's death within 12 months; and
2. from which the covered person is not expected to recover.

Eligibility

All covered employees under age 70 who are insured for a minimum of $10,000 of life insurance under the policy are eligible.

A covered employee is eligible for the accelerated benefit only if he becomes and remains insured for life insurance under the policy.

Accelerated Benefit

The accelerated benefit is an advance payment to the covered person who:

1. is terminally ill; and
2. elects to receive part of his life insurance benefit payable under the group policy, subject to the maximum benefit amounts stated on the Schedule of Insurance.

We will pay an accelerated benefit to you when we receive the following:

1. a written request for payment of the accelerated benefit; and
2. proof that the covered person is terminally ill and his illness is expected to result in his death within 12 months.

The accelerated benefit will be paid only once for each eligible covered person, and in one lump sum to you before death occurs.

Cost of Providing the Accelerated Benefit

There is no cost associated with providing the accelerated benefit.

Amount of Accelerated Benefit

The maximum accelerated benefit will be the lesser of:

1. 75% of the covered person's life insurance amount; or
2. $250,000.

If the covered person's life insurance amount is scheduled for a reduction within 12 months after the date you request the payment of the accelerated benefit, the maximum accelerated benefit will be based on the reduced amount.

Irrevocable Beneficiary

For the purpose of the Accelerated Benefit provision, an irrevocable beneficiary is a named beneficiary whose rights to the employee's life insurance proceeds are vested and whose rights cannot be cancelled by the employee unless the irrevocable beneficiary consents.

Conditions and Requirements for Payment of the Accelerated Benefit

You must request payment of an accelerated benefit in writing.

Proof that the covered person is terminally ill must be provided to us. The proof must be certified by a licensed physician and in a form that is satisfactory to us. We are not obligated to ask for any proof. Any delay in submitting proof will not cause a request to be denied if the proof is given to us as soon as reasonably possible.

After receipt of such proof, we may require the covered person to be examined by a licensed physician of our choice, at our expense. If there is a disagreement between the two physicians, we may require the covered person to be examined by another licensed physician of our choice, at our expense. The decision of the third physician will be final.

Effect of Payment of an Accelerated Benefit on Policy Provisions

The covered person's amount of life insurance under the policy will be reduced by the amount of any accelerated benefit that has been previously paid.

The following will be based on the reduced life insurance amount:

1. the amount of life insurance payable to the beneficiary when the covered person dies;
2. the amount of life insurance the covered person can convert under the policy; and
3. the premiums payable for the covered person's life insurance under the policy after an accelerated benefit is paid to you, if such premiums are not waived.

Exclusions

We will not pay an accelerated benefit if:

1. the covered person has made an absolute assignment of his life insurance under the policy and we do not receive written consent by the absolute assignee;
2. all or part of the covered person's life insurance under the group policy is to be paid to his children or former spouse as part of a court approved divorce agreement;
3. the covered person has made an irrevocable beneficiary designation of his life insurance under the policy and we do not receive written consent by the irrevocable beneficiary; or
4. the terminal illness is a result of intentional self-inflicted injury or attempted suicide, committed while sane or insane.

Date Insurance Ends under this Benefit

A covered person's insurance under this benefit will end at the earliest of:

1. the date the accelerated benefit is paid to you on the covered person's behalf;
2. the date the covered person's life insurance ends under the policy; or
3. the policy anniversary on which the covered person is age 70.

Important Notice

The following information is provided to assist you in answering any questions you might have:

Soliciting Agent
The name, address and telephone number of our soliciting agent is available to you, if needed, by calling our Customer Service Department at [(800) 370-5856].

USAble Life

USAble Life
P. O. Box 1650
Little Rock, AR 72203-1650
Toll Free [(800) 370-5856]

If we fail to provide you with reasonable and adequate service, you may contact:

Arkansas Insurance Department

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Phone (501) 371-2640 or
Toll Free 1-800-852-5494

We appreciate the opportunity to serve your insurance needs.

ERISA Information

Plan Sponsorship and Administration

The plan was established by the actions of your employer, which continues to act as Plan Sponsor and Plan Administrator. Your employer, as Plan Administrator, performs the functions of distributing Plan notices and information to employees and other Plan participants, coordinates employees' and eligible dependents' enrollment in the Plan, and transmits Plan premium payments.

ERISA Rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.
4. Neither your employer, nor any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
5. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
6. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, provided that you have first followed the Plan's designated appeals procedure before bringing suit.
7. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees.
8. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
9. If you have any questions about your Plan, you should contact the Plan Administrator.
10. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

USAble Life

[320 W. Capitol] • P.O. Box 1650 • Little Rock, AR 72203-1650
[(501) 375-7200 • (800) 648-0271]

CERTIFICATE OF INSURANCE

Voluntary Accidental Death & Dismemberment

Policyholder: SIMMONS FIRST NATIONAL BANK

Class: 001 - SENIOR VICE PRESIDENTS AND ABOVE

State of Residence: ARKANSAS

This is to certify that USAble Life has issued and delivered the Insurance Policy to the Policyholder.

The policy insures the employees and their dependents, if elected, of the policyholder who:

1. eligible for the insurance;
2. become insured; and
3. continue to be insured;

according to the terms of the policy.

The terms of the policy that affect your insurance are contained in the following pages.

This Certificate of Insurance is a part of the policy. This certificate replaces any other that USAble Life may have issued to the policyholder to give to you under the Group Insurance Policy specified herein.

Signed for USAble Life:

James L. Tourse — Secretary

Jason Ram — President

Table of Contents

Schedule of Insurance

Policyholder: SIMMONS FIRST NATIONAL BANK

Group Policy Number: 50001328

Policy Effective Date: September 1, 2011*
*This certificate replaces any certificate issued before the date shown.

Eligible Class: Class 001 - SENIOR VICE PRESIDENTS AND ABOVE

Annual Enrollment Date: July 1 of each year

Full-time Employment: 30 hours weekly

Renewal Date: September 1, 2013

Waiting Period: You will be eligible for coverage on the first of the policy month following completion of the following period of continuous active work:

1. If you are working for the employer on the policy effective date – 0 days
2. If you start working for the employer after the policy effective date – 30 days

Benefits amounts for eligible employees shall be determined in accordance with the following schedule:

Benefit	Benefit Amount
Employee Voluntary Accidental Death & Dismemberment	The amount elected by you on your enrollment form. Elected in $10,000 increments up to a maximum of $500,000 or 5 times Basic Annual Salary, whichever is less.
Spouse Voluntary Accidental Death & Dismemberment	The amount elected by you on your enrollment form. Elected in $10,000 increments up to a maximum of $250,000.
Children Voluntary Accidental Death & Dismemberment	6 months and over: $5,000 or $10,000, as elected by you on your enrollment form. Age live birth to 6 months: $1,000
AD&D Coma Rider	5% per month for 11 months
AD&D Exposure & Disappearance Rider	AD&D benefit payable after 1 year of accidental disappearance
AD&D Repatriation Rider	10% up to $5,000
AD&D Seat Belt & Air Bag Rider	Seat Belt: 10% up to $10,000 Air Bag: 10% up to $10,000

Reductions, Terminations, and Special Provisions

Employee Voluntary Accidental Death & Dismemberment	Reduces to 65% at age 65 and to 50% at age 70. Terminates at retirement.
Spouse Voluntary Accidental Death & Dismemberment	Reduces to 65% at the spouse's age 65 and to 50% at the spouse's age 70. Terminates at retirement.

Definitions

The terms listed, if used, will have these meanings.

Accident or Injury mean accidental bodily injury sustained by the covered person while insured under the policy which is the direct cause of the loss, independent of disease or bodily infirmity or any other cause.

Active Work or Actively at Work mean the expenditure of time and energy for the policyholder or an associated company at your usual place of business on a full-time basis. If you are not working on a day your coverage would otherwise take effect, you will be considered to be at active work on that day only if:

1. when that work day begins, it would be reasonable to expect that you would be physically and mentally able to complete a full-time week of work in your regular occupation; and
2. you are not disabled; and
3. your contract of employment, if applicable, remains active; and
4. you are not on an unapproved, administrative or disciplinary leave; and
5. you return to work at the end of a paid break or vacation period.

Annual Enrollment Period means the 60 days prior to and the 30 days immediately following the Annual Enrollment Date shown in the Schedule of Insurance.

Annual Salary means your annual base rate of pay, excluding any overtime pay, bonuses, or other extra pay. If your pay is from commissions, your annual salary will be based on your average commissions for the prior 12 months.

Associated Company means any company shown in the application which is owned by or affiliated with the policyholder.

Beneficiary means the person or entity you choose to receive your amount of insurance at your death.

Contributory means you pay part of the premium.

Covered Person means an eligible employee or the employee's dependents whose insurance has become and remains effective under all the conditions and provisions of the policy. Covered persons do not include contract, temporary, seasonal, or part-time workers.

Dependent means an eligible person who is:

1. your spouse, if not legally separated from you;
2. any unmarried child less than age 25, who is:
   a. not working on a full-time basis, and
   b. depends upon you for more than 50% of his support; or
3. a handicapped child, as defined in the Continuation of Insurance for a Handicapped Child section, age 25 years or over, who was insured under this policy before reaching age 25.

The term "child" also includes a legally adopted child or child placed for adoption, stepchild, foster child, or any child who lives with you, and depends on you for more than 50% of his support.

Eligible Class means a class of persons eligible for insurance under the policy. This class is based on employment or membership in a group.

Eligible Persons means a person who:

1. is a citizen of the United States of America (U.S.) or Canada, who either:

a. resides in the U.S. or Canada; or
b. is stationed outside the U.S. or Canada for a period of less than 6 months; or

2. is a foreign national residing in the U.S. and meets all of the following requirements:
   a. has a valid permanent residency visa;
   b. participates in U.S. Social Security; and
   c. is covered by Workers' Compensation.

Employee means an eligible person who is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the policyholder or an associated company; or
4. a retiree, if listed as eligible in the policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the above conditions.

Employer means the policyholder.

Evidence of Insurability means a signed health and medical history form provided by us, a medical examination, if requested, and any additional information and attending physicians' statements that we may require.

Family Member means a person who is a parent, spouse, child, sibling, domestic partner, grandparent, grandchild, step-child, step-parent, step-sister, step-brother, father-in-law, or mother-in-law of the covered person; or spouses, as applicable, of any of these.

Full-time means working at least the number of hours indicated in the Schedule of Insurance for Full-time employment.

Gender – The use of the male pronoun also includes the female.

Home Office means the principal office of USAble Life in Little Rock, Arkansas.

Hospital means a facility supervised by one or more physicians and operated under state and local laws. It must have 24-hour nursing service by registered graduate nurses. It may specialize in treating alcoholism, drug addiction, chemical dependency, or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged.

Hospital Confined and Hospital Confinement mean staying in a hospital as a registered inpatient for 24 hours a day.

Material Duty or Material Duties mean the sets of tasks or skills required generally by employers from those engaged in an occupation. We will consider one material duty of your regular occupation to be the ability to work for an employer on a full-time basis as defined in the policy.

Noncontributory means the policyholder pays the premium.

Occupation means a group of jobs:

1. in which a common set of tasks is performed; or
2. which are related in terms of similar objectives and methodologies, and which may be related in terms of materials, products, worker actions, or worker characteristics.

Physician means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. This includes a person whom we are required to recognize as a physician by the laws or regulations of the governing jurisdiction. However, neither you nor a family member will be considered a physician.

Plan means the policy and certificates of insurance provided for covered persons.

Plan Administrator means the employer that sponsors the plan for the benefit of its employees and eligible dependents.

Policy means the group policy issued by us to the policyholder that describes the benefits for which you may be eligible.

Policyholder means the entity to which the policy is issued.

Regular Care means you personally visit a physician as often as is medically required to effectively manage and treat your disabling condition(s), according to generally accepted medical standards; and you are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the sickness or injury causing your disability must be given by a physician whose specialty or experience is appropriate.

Regular Occupation means the occupation in which you were working immediately prior to becoming disabled.

Retiree or Retirement means you begin receiving retirement benefits from either:

1. a retirement plan sponsored by your employer, the policyholder, or an associated company, or
2. a government plan.

Sickness means a disease or illness, including pregnancy.

United States of America means the fifty (50) states of the United States and the District of Columbia. It does not include territories of the United States.

Waiting Period is the number of continuous days of service during which you must be an active, full-time employee in a class eligible for insurance before you become eligible for coverage.

We, Us, and Our mean USAble Life.

You and Your mean an employee of the policyholder or an associated company who has met all the eligibility requirements for coverage, and is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the employer, or associated company covered under the policy; or
4. a retiree, if listed as eligible in the group Policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the conditions listed above.

Eligibility and Effective Date Provisions

Eligible Employee

If you are working on a full-time basis for the employer, you are eligible for insurance after completion of the required waiting period, provided you are in a class of employees who are included.

Employee Eligibility Date

If you are working for your employer in an eligible class, the date you are eligible for coverage is the latest of the following dates:

1. the policy effective date;
2. the day after you complete any waiting period shown in the Schedule of Insurance by continuous service with the employer, the policyholder, or an associated company;
3. the date the policy is changed to include your class; or
4. the date you become a member of a class eligible for insurance.

If you do not apply for voluntary coverage when you are first eligible, you will again be eligible on the first Annual Enrollment Date as shown in the Schedule of Insurance which immediately follows the date noted in items 2, 3, or 4 above.

Effective Date of Employee Insurance

You must use forms approved by us when applying for insurance.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When your Employer pays 100% of the cost of your coverage under the policy, you will be covered at 12:01 a.m. at your employer's address on your eligibility date.
2. When you and your Employer share the cost of your coverage under the policy or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. at your employer's address on the latest of the following dates:
   a. on your eligibility date, if you enroll for insurance within 31 days after the date you first become eligible for coverage; or
   b. on the first day of the policy month following the date we approve your application if you do not apply for insurance within 31 days after your eligibility date; or
   c. for voluntary coverage only, on the Annual Enrollment Date as shown in the Schedule of Insurance if you enroll during the annual enrollment period. If you do not apply for voluntary coverage during the first annual enrollment period following your eligibility date, you will be required to submit satisfactory evidence of insurability.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, your coverage will be effective on the first day of the policy month following the date we approve your application.

Delayed Effective Date

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, it will take effect on the day you return to active work. If your insurance is scheduled to take effect on a non-working day, your active work status will be based on the last working day before the scheduled effective date of your insurance.

Dependent Eligibility

Dependents are eligible for insurance on the latest of the following dates:

1. the date you become eligible for dependent insurance;
2. the date a person becomes a dependent; or

3. the date the policy is amended to include your class as being eligible for dependent insurance.

If you do not apply for voluntary dependent coverage when you are first eligible, you will again be eligible on the first Annual Enrollment Date as shown in the Schedule of Insurance which immediately follows the date noted in items 1, 2, or 3 above.

Your spouse or child will not be eligible for dependent insurance if either is insured under the policy as an employee.

If both you and your spouse are insured as employees, your eligible children may be insured as dependents of only one of you.

Effective Date of Dependent Insurance

You must use forms approved by us when applying for dependent insurance.

Dependents will not be insured until you are insured.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When your Employer pays 100% of the cost of your dependent coverage under the policy, your dependents will be covered at 12:01 a.m. at your employer's address on your dependent's eligibility date.
2. When you and your Employer share the cost of your dependent coverage under the policy or when you pay 100% of the cost yourself, your dependents will be covered at 12:01 a.m. at your employer's address on the latest of the following dates:
   a. on your dependent's eligibility date, if you enroll for dependent coverage within 31 days after the date your dependent first becomes eligible for coverage; or
   b. on the first day of the policy month following the date we approve your application for dependent coverage if you do not apply for dependent coverage within 31 days after your dependent's eligibility date; or
   c. for voluntary coverage only, on the Annual Enrollment Date as shown in the Schedule of Insurance if you enroll during the annual enrollment period. If you do not apply for voluntary dependent coverage during the first annual enrollment period following your dependent's eligibility date, you will be required to submit satisfactory evidence of insurability.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, your dependent's coverage will be effective on the first day of the policy month following the date we approve your application for dependent coverage.

You must furnish satisfactory evidence of the dependent's insurability at your own expense if you have previously terminated dependent coverage while in an eligible class.

Delayed Effective Date

Coverage for a dependent, other than a newborn child, who is confined in a hospital on the day dependent insurance or an increase in insurance is scheduled to take effect will not become effective until the 10th day following final discharge from the hospital.

Newborn Child Coverage (including children placed for adoption)

This section applies to the Voluntary Accidental Death & Dismemberment Benefit only.

Any child of yours born while this benefit is in force will be immediately covered as a dependent from the moment of birth for 90 days. Any newly adopted child or child placed for adoption will be immediately covered from the moment of placement for 90 days. In order for coverage to continue beyond 90 days we must receive: (1) written notice of the birth of the newborn child or

the date of placement for adoption; and (2) payment of any required additional premium within 31 days of our notifying the policyholder of the amount. Additional premium, if any, will begin on the premium due date following the child's date of birth or date of placement, if later.

Written notice should include the child's name, date of birth, and, if applicable, date placed for adoption. We must receive this notice by the end of the 90-day period following the date of birth or adoption placement. Notice is NOT required if you are already paying the premium for children's coverage.

If the required written notice is not received by us during the 90-day period, a newborn child or child placed for adoption may be covered after this date only if the following conditions are met: (1) your written application for coverage is approved by us; and (2) the payment of any required premium is made.

Changes in Coverage Provisions

When Coverage Amounts Change (Redetermination Date)

The policy redetermines your amount of insurance on the first of the policy month after a change occurs. If benefits are based on your salary, the policyholder must report updates to all covered person's earnings as they occur. Changes to a covered person's earnings are subject to any proof of insurability requirements of the policy. As of the policy's redetermination date, we use a covered person's salary or earnings on record with us to: (a) set rates; (b) set benefit amounts and limits; and (c) calculate premium payable under the policy.

Delayed Effective Date of Change

You must be actively at work on a full-time basis on the redetermination date. If you are not, your coverage amount will not change until the date you return to active work on a full-time basis. Changes in salary or earnings will not apply to a recurring disability.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

Changes to the Policy

Any increase or decrease in coverage because of a change in the plan of insurance will become effective on the date of the change. The Delayed Effective Date provision will apply to an increase.

Termination Provisions

Termination of Employee Insurance

Your insurance will terminate at 12:00 midnight on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date the policy terminates, or the date a specified benefit terminates;
3. the date you cease to be a member of a class eligible for insurance;
4. the date you cease to be actively at work.

Termination of Dependent Insurance

Insurance on a dependent will terminate at 12:00 midnight on the earliest of the following dates:

1. the date he ceases to be a dependent as defined in the Definitions section;
2. the date you cease to be an employee or a member of a class eligible for dependent insurance;
3. the last day of the period for which a required dependent premium payment is made, if the next payment is not made; or
4. the date the policy terminates, or a specific benefit terminates.

Continuation of Insurance for a Handicapped Dependent Child

If an unmarried dependent child is not capable of self-sustaining employment due to mental or physical handicap, his insurance will not terminate at age 25. The insurance will continue as long as the child remains handicapped, unless coverage terminates as described in the Termination of Dependent Insurance section, if you give us proof that the child is:

1. incapable of self-sustaining employment; and
2. chiefly dependent on you for support and maintenance.

To keep this coverage in force, we may require proof at our expense of the child's incapacity and dependence. We may require proof from time to time, but not more than once a year after the two years that follow the date the child reaches age 25.

Claim Provisions

Notice of Loss

Written notice of claim must be given to us at our Home Office within 30 days after a loss occurs or begins, or as soon after the loss as is reasonably possible to do so, but not later than one (1) year from the time notice is required. The notice should identify the covered person and the nature of the loss.

Within 15 days after the date of your notice, we will send you claim forms. The forms must be completed and sent to our Home Office. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.

Proof of Loss

For any loss for which the policy provides periodic payment contingent upon continuing loss, written proof of loss must be given to us within 90 days after the termination of the period for which we are liable. For any other loss covered by the policy, written proof of loss must be given to us within 90 days after the date of such loss. Failure to furnish proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time. Such proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof was otherwise required.

Physical Examination and Autopsy

We have the right to have a physician of our choice examine the covered person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.

Payment of Claims

All benefits payable under this policy will be payable immediately upon receipt of due written proof of such loss.

If included, Dismemberment benefits will be paid to you. Accidental Death benefits will be paid to the person(s) named by you to receive them.

If you failed to name a beneficiary or if no named beneficiary is living at your death, refer to the "Beneficiary" provision below. At our option, up to the maximum allowable by the state laws of the covered person's state of residence may be paid to any person who incurred funeral or other expenses related to the last illness or death of the covered person.

Beneficiary

Your beneficiary will be the person(s) you name in writing to receive any amount of insurance payable due to your death. The beneficiary's name is on record in our Home Office, or in the policyholder's office if the group is self-administered. You are the beneficiary of the Dependent Life Insurance if you are living. If you and your dependent die in the same accident, the dependent benefit will be paid to your estate.

You may name or change a beneficiary by giving us written notice at our Home Office (or by giving the policyholder written notice if the group is self-administered) on a form acceptable to us. When we receive the notice, it will be effective on the date made, subject to any payment we may have made before we receive it.

If there is no named beneficiary living at your death, we may pay, at our discretion, any amount due to one of the following classes of survivors: (1) your spouse; (2) your surviving children in equal shares; (3) your mother and/or father; (4) your brother and/or sister; or (5) your estate.

Assignment

You may transfer your rights to name or change the beneficiary to someone else by assignment. An assignment will affect us only if it is in writing on a form acceptable to us, and is received at our Home Office. When we record it, the assignment will take effect as of the date you made it. The assignment will be subject to any action we may have taken before we record it. We take no responsibility for the validity of any assignment.

Claims of Creditors**:** To the extent allowed by law, proceeds will not be subject to any claims of a beneficiary's creditors.

Authority

The policyholder delegates to us and agrees that we have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the policy.

We decide: (a) if a covered person is eligible for this insurance; (b) if a covered person meets the requirements for benefits to be paid; and (c) what benefits are to be paid by the policy. We also interpret how the policy is to be administered. What we pay and the terms for payment are explained in this certificate.

Limit on Legal Action

No action at law or in equity may be brought against the policy until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations has expired, but, in any case, not after three (3) years from the date of loss.

Review Procedure

You must request, in writing, a review of a denial of your claim within 180 days after you receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit written comments, documents, records and other information relating to your claim for benefits.

We will review your claim after receiving your request and send you a notice of our decision within 45 days after we receive your request, or within 90 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant provisions of the policy. We will also advise you of your further appeal rights, if any.

Subrogation and Right of Reimbursement

The plan assumes and is subrogated to your legal rights to recover any payments the plan makes for benefits, when a covered sickness or injury resulted from the action or fault of a third party. The plan's subrogation rights include the right to recover the amount of benefits paid to you.

The plan has the right to recover any and all amounts equal to the plan's payments from:

1. the insurance of the injured party;
2. the person, company (or combination thereof) that caused the sickness or injury, or any insurance company; or
3. any other source, including disability benefit coverage.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The plan's recovery will not be reduced by your negligence, nor by attorney fees and costs you incur.

Priority Right of Reimbursement

Separate and apart from the plan's right of subrogation, the plan shall have first lien and right to reimbursement. This priority right of reimbursement supersedes your right to be made whole from any recovery, whether full or partial. You agree to reimburse the plan 100% first for any and all benefits provided through the plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

1. any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from your own insurance and/or from the third party (or their insurance);
2. any auto or recreational vehicle insurance coverage or benefits including, but not limited to disability benefit coverage; and
3. business and homeowner disability insurance coverage or payments.

The plan may notify those parties of its lien and right to reimbursement without notice to or consent from any covered person.

This priority right of reimbursement will not be reduced by attorney fees and costs you incur.

The plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available disability insurance coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

Notice and Cooperation

You are required to notify us promptly if you are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable us to protect the plan's rights under this section. You are also required to cooperate with us and to execute any documents that we, acting on behalf of the policyholder, deems necessary to protect the plan's rights under this section.

You shall not do anything to hinder, delay, impede or jeopardize the plan's subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the plan to withhold any and all benefits due you under the plan. This is in addition to any and all other rights that the plan has pursuant to the provisions of the plan's subrogation rights and/or priority right of reimbursement.

If the plan has to file suit, or otherwise litigate to enforce its subrogation rights and/or priority right of reimbursement, you are responsible for paying any and all costs, including attorneys' fees, the plan incurs in addition to the amounts recovered through the subrogation rights and/or priority right of reimbursement.

Legal Action and Costs

If a covered person settles any claim or action against any third party, that covered person shall be deemed to have been made whole by the settlement and the plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. The covered person shall hold any such proceeds of settlement or judgment in trust for the benefit of the plan. The plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the covered person in such circumstances.

Additionally, the plan has the right to sue on the covered person's behalf, against any person or entity considered responsible for any condition resulting in benefits paid or to be paid by the plan.

Settlement or Other Compromise

The covered person must notify the plan prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the plan's rights so that the plan may be present and protect its subrogation rights and/or priority right of reimbursement.

The plan's subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against the covered person.

The right of subrogation and the right of reimbursement are based on the plan language in effect at the time of judgment, payment, or settlement.

The plan, or its representative, may enforce the subrogation and priority right of reimbursement.

Alternate Dispute Resolution Procedures

This dispute resolution procedure ("procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all disputes with us. Such disputes include any matters that cause you to be dissatisfied with any aspect of your relationship with us, including any claim, controversy, or potential cause of action you may have against us. Please contact the Dispute Resolution office at (800) 648-0271 if you have any questions about this section of the certificate or to begin the dispute resolution process.

The following terms are applicable to all disputes:

1. This procedure is the exclusive method of resolving any disputes.
2. The procedure can only resolve disputes that are subject to our control.
3. This procedure will be governed by the Employee Retirement Income Security Act of 1974 ("ERISA"); Rules and Regulations for Administration and Enforcement; Claims Procedure (the "Claims Regulation"). That includes the definition of an adverse benefit determination, which is defined as any denial, reduction, termination or failure to provide or make payment for what you believe should be a covered benefit.
4. You may request a form from our Dispute Resolution office to authorize another person to act on your behalf concerning a dispute.
5. We may elect to skip one or more of the steps of this procedure if it is determined that step will not help to resolve the dispute.
6. Any dispute will be resolved in accordance with the terms of this certificate, applicable state or Federal laws and regulations.
7. You must begin the dispute process within 180 days from the date you receive notice of an adverse benefit determination. If you do not initiate the dispute process within that 180 day period, you give up the right to take any action based on that Dispute.

Description of the Procedure

Inquiry

You should contact our Dispute Resolution office to discuss and attempt to resolve any issues regarding a dispute. We hope that this informal process will resolve your questions or concerns.

Appeals

If you are not satisfied with the response to your inquiry, you may submit a written request (an "appeal") to the Office of the Appeals Coordinator, USAble Life, P.O. Box 1650, Little Rock, AR 72203-1650, asking that we reconsider an adverse benefit determination. Please contact the Dispute Resolution office if you have any questions about how to submit an appeal to us. You are not required to use a specific form, but you may request that the Dispute Resolution office send you a blank appeal form to ensure that you provide the information that will be needed to review your appeal.

We will assign a coordinator to review your appeal. The appeal coordinator is an individual with appropriate expertise who is neither the individual who made the adverse benefit determination, nor a subordinate of that individual.

The appeal coordinator may request that you submit additional information concerning your grievance. The appeal coordinator will also consider information submitted by others, including information requested from other USAble Life representatives. The appeal coordinator will have full discretionary authority to make eligibility, benefit or claim determinations and construe the terms of the policy. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the policy is not governed by ERISA.

We will make a decision within 60 days after receiving your appeal concerning a claim determination.

The appeal coordinator will send you a written decision concerning your appeal. The appeal coordinator's decision will include: a statement of the coordinator's understanding of your appeal; a statement explaining the basis of the decision; and a list of the documents or information upon which that decision was based. We will send you a copy of the listed documents, without charge, if you make a written request for such documents.

Post Appeal Procedure

If you are still not satisfied after completing the appeal procedure, you have the right to bring a civil action against us to obtain the remedies available pursuant to Sec. 502(a) of ERISA (an "ERISA Action") after completing the mandatory appeal process. Those ERISA remedies will apply to this policy even if your plan is not otherwise governed by ERISA. If you agree to arbitrate a dispute, we agree to suspend (or toll) any time periods affecting your right to bring an ERISA Action against us related to that dispute, until the arbitration has been completed.

You may request that the dispute be submitted for resolution by arbitration. That arbitration request must be submitted, in writing, to USAble Life's General Counsel within sixty (60) days after you receive the appeal coordinator's decision.

The dispute will be submitted to arbitration in accordance with the rules of the American Arbitration Association, unless we both agree to use an alternative dispute resolution administrator or procedure. The arbitration will be conducted before a single arbitrator.

We will pay the filing fee charged by the administrator and the arbitrator. You will be solely responsible for any other costs that you incur to participate in the arbitration process, including your attorney's fees. The filing fee and arbitrator's fees may be reallocated as part of an arbitration award, in whole or in part, at the discretion of the arbitrator.

The arbitration will be conducted in a location where it is reasonably convenient for you to participate. If we cannot agree concerning a convenient location, the administrator or arbitrator, if appointed, shall have the discretion to decide where the arbitration will be conducted.

The arbitrator: (a) shall consider the dispute individually and shall not certify or consider multiple disputes as part of a class action; (b) shall be required to issue a reasoned written decision explaining the basis of his or her decision and the manner of calculating any award; (c) shall limit his or her decision to deciding if our adverse benefit decision was arbitrary or capricious based on ERISA standards; (d) may not award punitive, extra-contractual, treble or exemplary damages unless permitted to do so by applicable statutes or regulations; (e) may not vary or disregard the terms of the policy; and (f) shall be bound by controlling law; when issuing a decision concerning the dispute.

The arbitrator shall limit discovery to the extent possible consistent with the objective of completing the arbitration in a fair, prompt, and cost effective manner. Emergency relief such as injunctive relief may be awarded by the arbitrator.

Contact Information

General Counsel
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: [(800) 648-0271]
Email: AppealCoordinator@usablelife.com

Office of the Dispute Resolution Coordinator
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
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General Provisions

Entire Contract

This certificate is furnished in accordance with and subject to the terms of the policy. The entire contract consists of the policy, which includes the application, any amendments and addenda; this certificate; your enrollment form, if required; and any riders or endorsements. No change in the policy will be effective until approved by one of our officers. This approval can only be in writing and must be noted on or attached to the policy. No agent has authority to change the policy or certificate or to waive any of their provisions.

Any statement made by you or the policyholder is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about you or the policyholder's plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

Incontestability

Unless the premiums have not been paid, the validity of the policy cannot be contested after it has been in force for two years.

Any statement made by the policyholder or a covered person will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the covered person or the beneficiary.

No statement, except fraudulent misstatement, made by a covered person about insurability will be used to deny a claim for a loss incurred or disability starting after coverage has been in effect for two years.

No claim for loss starting two or more years after the covered person's effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Agency

Neither the policyholder, any employer, any associated company, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

Unpaid Premium

We may deduct any unpaid premium then due from the payment of a claim under this certificate.

Refund of Premium

On the death of the covered person, proceeds payable hereunder shall include the amount of unearned premium paid beyond the end of the policy month in which death occurred. Payment shall be made in one lump sum no later than 30 days after proof of the covered person's death has been furnished to us.

Conformity with State Statutes

If the provisions of this certificate do not conform with the laws of the state in which you reside on the certificate effective date, they are hereby amended to conform with the minimum requirements of the statutes of that state.

Policy Management

Efficient management of the policy requires the joint efforts of the policyholder, USAble Life, and each covered person. Each party has certain duties to bring about the effective administration of the policy.

Duties of the Policyholder: The policyholder's primary duties under the policy are listed below.

1. Give us prompt, written notice of any change in business of the policyholder and employer. This includes, but is not limited to: (a) the type of business; (b) addition or deletion of an associated company; or (c) financial status due to bankruptcy; merger; acquisition; or dissolution.
2. Give us pertinent records for all covered persons. This includes, but is not limited to: (a) hire dates; (b) eligibility dates; (c) salaries; (d) occupations; and (e) birth dates. Give us updates of such records as needed.
3. Give us prompt notice of a covered person's disability. This notice should be given as soon as possible after the date of injury or start of sickness. The most effective time for such notice is when the covered person has not been able to perform active work for 30 days.
4. Give us occupational data for all disabled covered persons. This includes, but is not limited to: (a) job descriptions and analyses; and (b) environmental factors.

Duties of Covered Persons and Beneficiaries: Your and your beneficiary's primary duties under the policy are listed below:

1. Give notice and proof of loss as soon as possible after the date of your injury or sickness, or the date of your death, or the death of a covered dependent, if applicable.
2. Give a complete account of the details of your injury or sickness or the death on a form approved by us.
3. Provide any other official documents to review the loss such as a certified death certificate, investigating officer's report, or medical records.
4. Allow release of medical and income data needed to adjudicate your claim.
5. Provide evidence of the regular care of a physician, if necessary.
6. Promptly report to us any changes in your status such as your address or telephone number, or if you return to work or are no longer disabled.
7. If benefits are overpaid, reimburse such overpayment within 60 days of the date benefits were overpaid.
8. Provide proof of your earnings for the period prior to a loss.

Fraud

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the policy and recovery of any amounts we have paid.

Accidental Death & Dismemberment Insurance

This section applies to the Voluntary Accidental Death & Dismemberment Benefit.

For Voluntary AD&D, you and any dependents covered under the Voluntary AD&D benefit are covered persons under this benefit.

If a covered person suffers a loss described below, we will pay the amount of insurance that applies. You or your beneficiary must give us proof that:

1. injury occurred while the insurance was in force under this section;
2. loss occurred within 365 days after the injury; and
3. loss was due to injury independent of all other causes.

Amount of Insurance

If a covered person suffers a specified loss, we will pay the benefit set opposite such loss; provided, however, that if the covered person sustains more than one such loss as the result of any one accident, we will pay only the one largest amount to which the covered person is entitled. In paying the benefit, we will consider only losses sustained while insured under this benefit.

Loss of Life .....100% of the AD&D Amount

Loss of Two or More Members.....100% of the AD&D Amount

Loss of One Member.....50% of the AD&D Amount

Loss of Thumb and Index Finger
of the Same Hand .....25% of the AD&D Amount

Member means hand, foot, sight, speech, or hearing.

Loss of sight means total and irrecoverable loss of sight.

Loss of hands or feet means total and irrecoverable loss due to severance at or above the wrist or ankle, unless the state in which the policy is issued defines the loss differently.

Loss of Thumb and Index Finger means total and irrecoverable loss at the proximal phalanx.

Loss of speech means a total and irrecoverable loss of audible communication.

Loss of hearing means permanent total deafness in both ears such that it cannot be corrected to any functional degree by any aid or device.

Exclusions

We will not pay a benefit for a loss caused directly or indirectly by:

1. disease, bodily or mental infirmity, or infection (except bacterial infection of a visible injury);
2. war or any act of war, or while serving in the armed forces of any country or international authority;
3. suicide or intentional, self-inflicted injury, whether sane or insane;
4. your active participation in a riot or insurrection;
5. your voluntary commission of, or attempting to commit, an assault or felony; or participating in an illegal occupation;
6. your voluntary use of any drug, hallucinogen, controlled substance, or narcotic unless taken as prescribed by a physician;

7. travel or flight in, or descent from, any aircraft unless as a fare paying passenger on a commercial airline flying between established airports on: (a) a scheduled route, or (b) a charter flight;
8. your being intoxicated as defined by the laws of the jurisdiction in which the accident occurred. Conviction is not necessary for a determination of being intoxicated.

Participation in a riot shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.

Riot shall include all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

War means declared or undeclared war or a conflict involving the armed forces of any country, group of countries, governments, or international organization.

Important Notice

The following information is provided to assist you in answering any questions you might have:

Soliciting Agent
The name, address and telephone number of our soliciting agent is available to you, if needed, by calling our Customer Service Department at [(800) 370-5856].

USAble Life

USAble Life
P. O. Box 1650
Little Rock, AR 72203-1650
Toll Free [(800) 370-5856]

If we fail to provide you with reasonable and adequate service, you may contact:

Arkansas Insurance Department

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Phone (501) 371-2640 or
Toll Free 1-800-852-5494

We appreciate the opportunity to serve your insurance needs.

ERISA Information

Plan Sponsorship and Administration

The plan was established by the actions of your employer, which continues to act as Plan Sponsor and Plan Administrator. Your employer, as Plan Administrator, performs the functions of distributing Plan notices and information to employees and other Plan participants, coordinates employees' and eligible dependents' enrollment in the Plan, and transmits Plan premium payments.

ERISA Rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.
4. Neither your employer, nor any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
5. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
6. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, provided that you have first followed the Plan's designated appeals procedure before bringing suit.
7. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees.
8. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
9. If you have any questions about your Plan, you should contact the Plan Administrator.
10. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

USAble Life

[320 W. Capitol] • P.O. Box 1650 • Little Rock, AR 72203-1650
[(501) 375-7200 • (800) 648-0271]

CERTIFICATE OF INSURANCE

Voluntary Accidental Death & Dismemberment

Policyholder: SIMMONS FIRST NATIONAL BANK

Class: 002 - ALL FULL TIME ACTIVE EMPLOYEES

State of Residence: ARKANSAS

This is to certify that USAble Life has issued and delivered the Insurance Policy to the Policyholder.

The policy insures the employees and their dependents, if elected, of the policyholder who:

1. eligible for the insurance;
2. become insured; and
3. continue to be insured;

according to the terms of the policy.

The terms of the policy that affect your insurance are contained in the following pages.

This Certificate of Insurance is a part of the policy. This certificate replaces any other that USAble Life may have issued to the policyholder to give to you under the Group Insurance Policy specified herein.

Signed for USAble Life:

James L. Tourse — Secretary

Jason Ram — President

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Schedule of Insurance

Policyholder: SIMMONS FIRST NATIONAL BANK

Group Policy Number: 50001328

Policy Effective Date: September 1, 2011*
*This certificate replaces any certificate issued before the date shown.

Eligible Class: Class 002 – ALL FULL TIME ACTIVE EMPLOYEES

Annual Enrollment Date: July 1 of each year

Full-time Employment: 30 hours weekly

Renewal Date: September 1, 2013

Waiting Period: You will be eligible for coverage on the first of the policy month following completion of the following period of continuous active work:

1. If you are working for the employer on the policy effective date – 0 days
2. If you start working for the employer after the policy effective date – 30 days

Benefits amounts for eligible employees shall be determined in accordance with the following schedule:

Benefit	Benefit Amount
Employee Voluntary Accidental Death & Dismemberment	The amount elected by you on your enrollment form. Elected in $10,000 increments up to a maximum of $500,000 or 5 times Basic Annual Salary, whichever is less.
Spouse Voluntary Accidental Death & Dismemberment	The amount elected by you on your enrollment form. Elected in $10,000 increments up to a maximum of $250,000.
Children Voluntary Accidental Death & Dismemberment	6 months and over: $5,000 or $10,000, as elected by you on your enrollment form. Age live birth to 6 months: $1,000
AD&D Coma Rider	5% per month for 11 months
AD&D Exposure & Disappearance Rider	AD&D benefit payable after 1 year of accidental disappearance
AD&D Repatriation Rider	10% up to $5,000
AD&D Seat Belt & Air Bag Rider	Seat Belt: 10% up to $10,000 Air Bag: 10% up to $10,000

Reductions, Terminations, and Special Provisions

Employee Voluntary Accidental Death & Dismemberment	Reduces to 65% at age 65 and to 50% at age 70. Terminates at retirement.
Spouse Voluntary Accidental Death & Dismemberment	Reduces to 65% at the spouse's age 65 and to 50% at the spouse's age 70. Terminates at retirement.

Definitions

The terms listed, if used, will have these meanings.

Accident or Injury mean accidental bodily injury sustained by the covered person while insured under the policy which is the direct cause of the loss, independent of disease or bodily infirmity or any other cause.

Active Work or Actively at Work mean the expenditure of time and energy for the policyholder or an associated company at your usual place of business on a full-time basis. If you are not working on a day your coverage would otherwise take effect, you will be considered to be at active work on that day only if:

1. when that work day begins, it would be reasonable to expect that you would be physically and mentally able to complete a full-time week of work in your regular occupation; and
2. you are not disabled; and
3. your contract of employment, if applicable, remains active; and
4. you are not on an unapproved, administrative or disciplinary leave; and
5. you return to work at the end of a paid break or vacation period.

Annual Enrollment Period means the 60 days prior to and the 30 days immediately following the Annual Enrollment Date shown in the Schedule of Insurance.

Annual Salary means your annual base rate of pay, excluding any overtime pay, bonuses, or other extra pay. If your pay is from commissions, your annual salary will be based on your average commissions for the prior 12 months.

Associated Company means any company shown in the application which is owned by or affiliated with the policyholder.

Beneficiary means the person or entity you choose to receive your amount of insurance at your death.

Contributory means you pay part of the premium.

Covered Person means an eligible employee or the employee's dependents whose insurance has become and remains effective under all the conditions and provisions of the policy. Covered persons do not include contract, temporary, seasonal, or part-time workers.

Dependent means an eligible person who is:

1. your spouse, if not legally separated from you;
2. any unmarried child less than age 25, who is:
   a. not working on a full-time basis, and
   b. depends upon you for more than 50% of his support; or
3. a handicapped child, as defined in the Continuation of Insurance for a Handicapped Child section, age 25 years or over, who was insured under this policy before reaching age 25.

The term "child" also includes a legally adopted child or child placed for adoption, stepchild, foster child, or any child who lives with you, and depends on you for more than 50% of his support.

Eligible Class means a class of persons eligible for insurance under the policy. This class is based on employment or membership in a group.

Eligible Persons means a person who:

1. is a citizen of the United States of America (U.S.) or Canada, who either:

a. resides in the U.S. or Canada; or
b. is stationed outside the U.S. or Canada for a period of less than 6 months; or

2. is a foreign national residing in the U.S. and meets all of the following requirements:
   a. has a valid permanent residency visa;
   b. participates in U.S. Social Security; and
   c. is covered by Workers' Compensation.

Employee means an eligible person who is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the policyholder or an associated company; or
4. a retiree, if listed as eligible in the policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the above conditions.

Employer means the policyholder.

Evidence of Insurability means a signed health and medical history form provided by us, a medical examination, if requested, and any additional information and attending physicians' statements that we may require.

Family Member means a person who is a parent, spouse, child, sibling, domestic partner, grandparent, grandchild, step-child, step-parent, step-sister, step-brother, father-in-law, or mother-in-law of the covered person; or spouses, as applicable, of any of these.

Full-time means working at least the number of hours indicated in the Schedule of Insurance for Full-time employment.

Gender – The use of the male pronoun also includes the female.

Home Office means the principal office of USAble Life in Little Rock, Arkansas.

Hospital means a facility supervised by one or more physicians and operated under state and local laws. It must have 24-hour nursing service by registered graduate nurses. It may specialize in treating alcoholism, drug addiction, chemical dependency, or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged.

Hospital Confined and Hospital Confinement mean staying in a hospital as a registered inpatient for 24 hours a day.

Material Duty or Material Duties mean the sets of tasks or skills required generally by employers from those engaged in an occupation. We will consider one material duty of your regular occupation to be the ability to work for an employer on a full-time basis as defined in the policy.

Noncontributory means the policyholder pays the premium.

Occupation means a group of jobs:

1. in which a common set of tasks is performed; or
2. which are related in terms of similar objectives and methodologies, and which may be related in terms of materials, products, worker actions, or worker characteristics.

Physician means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. This includes a person whom we are required to recognize as a physician by the laws or regulations of the governing jurisdiction. However, neither you nor a family member will be considered a physician.

Plan means the policy and certificates of insurance provided for covered persons.

Plan Administrator means the employer that sponsors the plan for the benefit of its employees and eligible dependents.

Policy means the group policy issued by us to the policyholder that describes the benefits for which you may be eligible.

Policyholder means the entity to which the policy is issued.

Regular Care means you personally visit a physician as often as is medically required to effectively manage and treat your disabling condition(s), according to generally accepted medical standards; and you are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the sickness or injury causing your disability must be given by a physician whose specialty or experience is appropriate.

Regular Occupation means the occupation in which you were working immediately prior to becoming disabled.

Retiree or Retirement means you begin receiving retirement benefits from either:

1. a retirement plan sponsored by your employer, the policyholder, or an associated company, or
2. a government plan.

Sickness means a disease or illness, including pregnancy.

United States of America means the fifty (50) states of the United States and the District of Columbia. It does not include territories of the United States.

Waiting Period is the number of continuous days of service during which you must be an active, full-time employee in a class eligible for insurance before you become eligible for coverage.

We, Us, and Our mean USAble Life.

You and Your mean an employee of the policyholder or an associated company who has met all the eligibility requirements for coverage, and is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the employer, or associated company covered under the policy; or
4. a retiree, if listed as eligible in the group Policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the conditions listed above.

Eligibility and Effective Date Provisions

Eligible Employee

If you are working on a full-time basis for the employer, you are eligible for insurance after completion of the required waiting period, provided you are in a class of employees who are included.

Employee Eligibility Date

If you are working for your employer in an eligible class, the date you are eligible for coverage is the latest of the following dates:

1. the policy effective date;
2. the day after you complete any waiting period shown in the Schedule of Insurance by continuous service with the employer, the policyholder, or an associated company;
3. the date the policy is changed to include your class; or
4. the date you become a member of a class eligible for insurance.

If you do not apply for voluntary coverage when you are first eligible, you will again be eligible on the first Annual Enrollment Date as shown in the Schedule of Insurance which immediately follows the date noted in items 2, 3, or 4 above.

Effective Date of Employee Insurance

You must use forms approved by us when applying for insurance.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When your Employer pays 100% of the cost of your coverage under the policy, you will be covered at 12:01 a.m. at your employer's address on your eligibility date.
2. When you and your Employer share the cost of your coverage under the policy or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. at your employer's address on the latest of the following dates:
   a. on your eligibility date, if you enroll for insurance within 31 days after the date you first become eligible for coverage; or
   b. on the first day of the policy month following the date we approve your application if you do not apply for insurance within 31 days after your eligibility date; or
   c. for voluntary coverage only, on the Annual Enrollment Date as shown in the Schedule of Insurance if you enroll during the annual enrollment period. If you do not apply for voluntary coverage during the first annual enrollment period following your eligibility date, you will be required to submit satisfactory evidence of insurability.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, your coverage will be effective on the first day of the policy month following the date we approve your application.

Delayed Effective Date

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, it will take effect on the day you return to active work. If your insurance is scheduled to take effect on a non-working day, your active work status will be based on the last working day before the scheduled effective date of your insurance.

Dependent Eligibility

Dependents are eligible for insurance on the latest of the following dates:

1. the date you become eligible for dependent insurance;
2. the date a person becomes a dependent; or

3. the date the policy is amended to include your class as being eligible for dependent insurance.

If you do not apply for voluntary dependent coverage when you are first eligible, you will again be eligible on the first Annual Enrollment Date as shown in the Schedule of Insurance which immediately follows the date noted in items 1, 2, or 3 above.

Your spouse or child will not be eligible for dependent insurance if either is insured under the policy as an employee.

If both you and your spouse are insured as employees, your eligible children may be insured as dependents of only one of you.

Effective Date of Dependent Insurance

You must use forms approved by us when applying for dependent insurance.

Dependents will not be insured until you are insured.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When your Employer pays 100% of the cost of your dependent coverage under the policy, your dependents will be covered at 12:01 a.m. at your employer's address on your dependent's eligibility date.
2. When you and your Employer share the cost of your dependent coverage under the policy or when you pay 100% of the cost yourself, your dependents will be covered at 12:01 a.m. at your employer's address on the latest of the following dates:
   a. on your dependent's eligibility date, if you enroll for dependent coverage within 31 days after the date your dependent first becomes eligible for coverage; or
   b. on the first day of the policy month following the date we approve your application for dependent coverage if you do not apply for dependent coverage within 31 days after your dependent's eligibility date; or
   c. for voluntary coverage only, on the Annual Enrollment Date as shown in the Schedule of Insurance if you enroll during the annual enrollment period. If you do not apply for voluntary dependent coverage during the first annual enrollment period following your dependent's eligibility date, you will be required to submit satisfactory evidence of insurability.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, your dependent's coverage will be effective on the first day of the policy month following the date we approve your application for dependent coverage.

You must furnish satisfactory evidence of the dependent's insurability at your own expense if you have previously terminated dependent coverage while in an eligible class.

Delayed Effective Date

Coverage for a dependent, other than a newborn child, who is confined in a hospital on the day dependent insurance or an increase in insurance is scheduled to take effect will not become effective until the 10th day following final discharge from the hospital.

Newborn Child Coverage (including children placed for adoption)

This section applies to the Voluntary Accidental Death & Dismemberment Benefit only.

Any child of yours born while this benefit is in force will be immediately covered as a dependent from the moment of birth for 90 days. Any newly adopted child or child placed for adoption will be immediately covered from the moment of placement for 90 days. In order for coverage to continue beyond 90 days we must receive: (1) written notice of the birth of the newborn child or

the date of placement for adoption; and (2) payment of any required additional premium within 31 days of our notifying the policyholder of the amount. Additional premium, if any, will begin on the premium due date following the child's date of birth or date of placement, if later.

Written notice should include the child's name, date of birth, and, if applicable, date placed for adoption. We must receive this notice by the end of the 90-day period following the date of birth or adoption placement. Notice is NOT required if you are already paying the premium for children's coverage.

If the required written notice is not received by us during the 90-day period, a newborn child or child placed for adoption may be covered after this date only if the following conditions are met: (1) your written application for coverage is approved by us; and (2) the payment of any required premium is made.

Changes in Coverage Provisions

When Coverage Amounts Change (Redetermination Date)

The policy redetermines your amount of insurance on the first of the policy month after a change occurs. If benefits are based on your salary, the policyholder must report updates to all covered person's earnings as they occur. Changes to a covered person's earnings are subject to any proof of insurability requirements of the policy. As of the policy's redetermination date, we use a covered person's salary or earnings on record with us to: (a) set rates; (b) set benefit amounts and limits; and (c) calculate premium payable under the policy.

Delayed Effective Date of Change

You must be actively at work on a full-time basis on the redetermination date. If you are not, your coverage amount will not change until the date you return to active work on a full-time basis. Changes in salary or earnings will not apply to a recurring disability.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

Changes to the Policy

Any increase or decrease in coverage because of a change in the plan of insurance will become effective on the date of the change. The Delayed Effective Date provision will apply to an increase.

Termination Provisions

Termination of Employee Insurance

Your insurance will terminate at 12:00 midnight on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date the policy terminates, or the date a specified benefit terminates;
3. the date you cease to be a member of a class eligible for insurance;
4. the date you cease to be actively at work.

Termination of Dependent Insurance

Insurance on a dependent will terminate at 12:00 midnight on the earliest of the following dates:

1. the date he ceases to be a dependent as defined in the Definitions section;
2. the date you cease to be an employee or a member of a class eligible for dependent insurance;
3. the last day of the period for which a required dependent premium payment is made, if the next payment is not made; or
4. the date the policy terminates, or a specific benefit terminates.

Continuation of Insurance for a Handicapped Dependent Child

If an unmarried dependent child is not capable of self-sustaining employment due to mental or physical handicap, his insurance will not terminate at age 25. The insurance will continue as long as the child remains handicapped, unless coverage terminates as described in the Termination of Dependent Insurance section, if you give us proof that the child is:

1. incapable of self-sustaining employment; and
2. chiefly dependent on you for support and maintenance.

To keep this coverage in force, we may require proof at our expense of the child's incapacity and dependence. We may require proof from time to time, but not more than once a year after the two years that follow the date the child reaches age 25.

Claim Provisions

Notice of Loss

Written notice of claim must be given to us at our Home Office within 30 days after a loss occurs or begins, or as soon after the loss as is reasonably possible to do so, but not later than one (1) year from the time notice is required. The notice should identify the covered person and the nature of the loss.

Within 15 days after the date of your notice, we will send you claim forms. The forms must be completed and sent to our Home Office. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.

Proof of Loss

For any loss for which the policy provides periodic payment contingent upon continuing loss, written proof of loss must be given to us within 90 days after the termination of the period for which we are liable. For any other loss covered by the policy, written proof of loss must be given to us within 90 days after the date of such loss. Failure to furnish proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time. Such proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof was otherwise required.

Physical Examination and Autopsy

We have the right to have a physician of our choice examine the covered person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.

Payment of Claims

All benefits payable under this policy will be payable immediately upon receipt of due written proof of such loss.

If included, Dismemberment benefits will be paid to you. Accidental Death benefits will be paid to the person(s) named by you to receive them.

If you failed to name a beneficiary or if no named beneficiary is living at your death, refer to the "Beneficiary" provision below. At our option, up to the maximum allowable by the state laws of the covered person's state of residence may be paid to any person who incurred funeral or other expenses related to the last illness or death of the covered person.

Beneficiary

Your beneficiary will be the person(s) you name in writing to receive any amount of insurance payable due to your death. The beneficiary's name is on record in our Home Office, or in the policyholder's office if the group is self-administered. You are the beneficiary of the Dependent Life Insurance if you are living. If you and your dependent die in the same accident, the dependent benefit will be paid to your estate.

You may name or change a beneficiary by giving us written notice at our Home Office (or by giving the policyholder written notice if the group is self-administered) on a form acceptable to us. When we receive the notice, it will be effective on the date made, subject to any payment we may have made before we receive it.

If there is no named beneficiary living at your death, we may pay, at our discretion, any amount due to one of the following classes of survivors: (1) your spouse; (2) your surviving children in equal shares; (3) your mother and/or father; (4) your brother and/or sister; or (5) your estate.

Assignment

You may transfer your rights to name or change the beneficiary to someone else by assignment. An assignment will affect us only if it is in writing on a form acceptable to us, and is received at our Home Office. When we record it, the assignment will take effect as of the date you made it. The assignment will be subject to any action we may have taken before we record it. We take no responsibility for the validity of any assignment.

Claims of Creditors**:** To the extent allowed by law, proceeds will not be subject to any claims of a beneficiary's creditors.

Authority

The policyholder delegates to us and agrees that we have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the policy.

We decide: (a) if a covered person is eligible for this insurance; (b) if a covered person meets the requirements for benefits to be paid; and (c) what benefits are to be paid by the policy. We also interpret how the policy is to be administered. What we pay and the terms for payment are explained in this certificate.

Limit on Legal Action

No action at law or in equity may be brought against the policy until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations has expired, but, in any case, not after three (3) years from the date of loss.

Review Procedure

You must request, in writing, a review of a denial of your claim within 180 days after you receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit written comments, documents, records and other information relating to your claim for benefits.

We will review your claim after receiving your request and send you a notice of our decision within 45 days after we receive your request, or within 90 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant provisions of the policy. We will also advise you of your further appeal rights, if any.

Subrogation and Right of Reimbursement

The plan assumes and is subrogated to your legal rights to recover any payments the plan makes for benefits, when a covered sickness or injury resulted from the action or fault of a third party. The plan's subrogation rights include the right to recover the amount of benefits paid to you.

The plan has the right to recover any and all amounts equal to the plan's payments from:

1. the insurance of the injured party;
2. the person, company (or combination thereof) that caused the sickness or injury, or any insurance company; or
3. any other source, including disability benefit coverage.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The plan's recovery will not be reduced by your negligence, nor by attorney fees and costs you incur.

Priority Right of Reimbursement

Separate and apart from the plan's right of subrogation, the plan shall have first lien and right to reimbursement. This priority right of reimbursement supersedes your right to be made whole from any recovery, whether full or partial. You agree to reimburse the plan 100% first for any and all benefits provided through the plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

1. any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from your own insurance and/or from the third party (or their insurance);
2. any auto or recreational vehicle insurance coverage or benefits including, but not limited to disability benefit coverage; and
3. business and homeowner disability insurance coverage or payments.

The plan may notify those parties of its lien and right to reimbursement without notice to or consent from any covered person.

This priority right of reimbursement will not be reduced by attorney fees and costs you incur.

The plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available disability insurance coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

Notice and Cooperation

You are required to notify us promptly if you are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable us to protect the plan's rights under this section. You are also required to cooperate with us and to execute any documents that we, acting on behalf of the policyholder, deems necessary to protect the plan's rights under this section.

You shall not do anything to hinder, delay, impede or jeopardize the plan's subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the plan to withhold any and all benefits due you under the plan. This is in addition to any and all other rights that the plan has pursuant to the provisions of the plan's subrogation rights and/or priority right of reimbursement.

If the plan has to file suit, or otherwise litigate to enforce its subrogation rights and/or priority right of reimbursement, you are responsible for paying any and all costs, including attorneys' fees, the plan incurs in addition to the amounts recovered through the subrogation rights and/or priority right of reimbursement.

Legal Action and Costs

If a covered person settles any claim or action against any third party, that covered person shall be deemed to have been made whole by the settlement and the plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. The covered person shall hold any such proceeds of settlement or judgment in trust for the benefit of the plan. The plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the covered person in such circumstances.

Additionally, the plan has the right to sue on the covered person's behalf, against any person or entity considered responsible for any condition resulting in benefits paid or to be paid by the plan.

Settlement or Other Compromise

The covered person must notify the plan prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the plan's rights so that the plan may be present and protect its subrogation rights and/or priority right of reimbursement.

The plan's subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against the covered person.

The right of subrogation and the right of reimbursement are based on the plan language in effect at the time of judgment, payment, or settlement.

The plan, or its representative, may enforce the subrogation and priority right of reimbursement.

Alternate Dispute Resolution Procedures

This dispute resolution procedure ("procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all disputes with us. Such disputes include any matters that cause you to be dissatisfied with any aspect of your relationship with us, including any claim, controversy, or potential cause of action you may have against us. Please contact the Dispute Resolution office at (800) 648-0271 if you have any questions about this section of the certificate or to begin the dispute resolution process.

The following terms are applicable to all disputes:

1. This procedure is the exclusive method of resolving any disputes.
2. The procedure can only resolve disputes that are subject to our control.
3. This procedure will be governed by the Employee Retirement Income Security Act of 1974 ("ERISA"); Rules and Regulations for Administration and Enforcement; Claims Procedure (the "Claims Regulation"). That includes the definition of an adverse benefit determination, which is defined as any denial, reduction, termination or failure to provide or make payment for what you believe should be a covered benefit.
4. You may request a form from our Dispute Resolution office to authorize another person to act on your behalf concerning a dispute.
5. We may elect to skip one or more of the steps of this procedure if it is determined that step will not help to resolve the dispute.
6. Any dispute will be resolved in accordance with the terms of this certificate, applicable state or Federal laws and regulations.
7. You must begin the dispute process within 180 days from the date you receive notice of an adverse benefit determination. If you do not initiate the dispute process within that 180 day period, you give up the right to take any action based on that Dispute.

Description of the Procedure

Inquiry

You should contact our Dispute Resolution office to discuss and attempt to resolve any issues regarding a dispute. We hope that this informal process will resolve your questions or concerns.

Appeals

If you are not satisfied with the response to your inquiry, you may submit a written request (an "appeal") to the Office of the Appeals Coordinator, USAble Life, P.O. Box 1650, Little Rock, AR 72203-1650, asking that we reconsider an adverse benefit determination. Please contact the Dispute Resolution office if you have any questions about how to submit an appeal to us. You are not required to use a specific form, but you may request that the Dispute Resolution office send you a blank appeal form to ensure that you provide the information that will be needed to review your appeal.

We will assign a coordinator to review your appeal. The appeal coordinator is an individual with appropriate expertise who is neither the individual who made the adverse benefit determination, nor a subordinate of that individual.

The appeal coordinator may request that you submit additional information concerning your grievance. The appeal coordinator will also consider information submitted by others, including information requested from other USAble Life representatives. The appeal coordinator will have full discretionary authority to make eligibility, benefit or claim determinations and construe the terms of the policy. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the policy is not governed by ERISA.

We will make a decision within 60 days after receiving your appeal concerning a claim determination.

The appeal coordinator will send you a written decision concerning your appeal. The appeal coordinator's decision will include: a statement of the coordinator's understanding of your appeal; a statement explaining the basis of the decision; and a list of the documents or information upon which that decision was based. We will send you a copy of the listed documents, without charge, if you make a written request for such documents.

Post Appeal Procedure

If you are still not satisfied after completing the appeal procedure, you have the right to bring a civil action against us to obtain the remedies available pursuant to Sec. 502(a) of ERISA (an "ERISA Action") after completing the mandatory appeal process. Those ERISA remedies will apply to this policy even if your plan is not otherwise governed by ERISA. If you agree to arbitrate a dispute, we agree to suspend (or toll) any time periods affecting your right to bring an ERISA Action against us related to that dispute, until the arbitration has been completed.

You may request that the dispute be submitted for resolution by arbitration. That arbitration request must be submitted, in writing, to USAble Life's General Counsel within sixty (60) days after you receive the appeal coordinator's decision.

The dispute will be submitted to arbitration in accordance with the rules of the American Arbitration Association, unless we both agree to use an alternative dispute resolution administrator or procedure. The arbitration will be conducted before a single arbitrator.

We will pay the filing fee charged by the administrator and the arbitrator. You will be solely responsible for any other costs that you incur to participate in the arbitration process, including your attorney's fees. The filing fee and arbitrator's fees may be reallocated as part of an arbitration award, in whole or in part, at the discretion of the arbitrator.

The arbitration will be conducted in a location where it is reasonably convenient for you to participate. If we cannot agree concerning a convenient location, the administrator or arbitrator, if appointed, shall have the discretion to decide where the arbitration will be conducted.

The arbitrator: (a) shall consider the dispute individually and shall not certify or consider multiple disputes as part of a class action; (b) shall be required to issue a reasoned written decision explaining the basis of his or her decision and the manner of calculating any award; (c) shall limit his or her decision to deciding if our adverse benefit decision was arbitrary or capricious based on ERISA standards; (d) may not award punitive, extra-contractual, treble or exemplary damages unless permitted to do so by applicable statutes or regulations; (e) may not vary or disregard the terms of the policy; and (f) shall be bound by controlling law; when issuing a decision concerning the dispute.

The arbitrator shall limit discovery to the extent possible consistent with the objective of completing the arbitration in a fair, prompt, and cost effective manner. Emergency relief such as injunctive relief may be awarded by the arbitrator.

Contact Information

General Counsel
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: [(800) 648-0271]
Email: AppealCoordinator@usablelife.com

Office of the Dispute Resolution Coordinator
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: [(800) 648-0271]
Email: AppealCoordinator@usablelife.com

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General Provisions

Entire Contract

This certificate is furnished in accordance with and subject to the terms of the policy. The entire contract consists of the policy, which includes the application, any amendments and addenda; this certificate; your enrollment form, if required; and any riders or endorsements. No change in the policy will be effective until approved by one of our officers. This approval can only be in writing and must be noted on or attached to the policy. No agent has authority to change the policy or certificate or to waive any of their provisions.

Any statement made by you or the policyholder is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about you or the policyholder's plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

Incontestability

Unless the premiums have not been paid, the validity of the policy cannot be contested after it has been in force for two years.

Any statement made by the policyholder or a covered person will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the covered person or the beneficiary.

No statement, except fraudulent misstatement, made by a covered person about insurability will be used to deny a claim for a loss incurred or disability starting after coverage has been in effect for two years.

No claim for loss starting two or more years after the covered person's effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Agency

Neither the policyholder, any employer, any associated company, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

Unpaid Premium

We may deduct any unpaid premium then due from the payment of a claim under this certificate.

Refund of Premium

On the death of the covered person, proceeds payable hereunder shall include the amount of unearned premium paid beyond the end of the policy month in which death occurred. Payment shall be made in one lump sum no later than 30 days after proof of the covered person's death has been furnished to us.

Conformity with State Statutes

If the provisions of this certificate do not conform with the laws of the state in which you reside on the certificate effective date, they are hereby amended to conform with the minimum requirements of the statutes of that state.

Policy Management

Efficient management of the policy requires the joint efforts of the policyholder, USAble Life, and each covered person. Each party has certain duties to bring about the effective administration of the policy.

Duties of the Policyholder: The policyholder's primary duties under the policy are listed below.

1. Give us prompt, written notice of any change in business of the policyholder and employer. This includes, but is not limited to: (a) the type of business; (b) addition or deletion of an associated company; or (c) financial status due to bankruptcy; merger; acquisition; or dissolution.
2. Give us pertinent records for all covered persons. This includes, but is not limited to: (a) hire dates; (b) eligibility dates; (c) salaries; (d) occupations; and (e) birth dates. Give us updates of such records as needed.
3. Give us prompt notice of a covered person's disability. This notice should be given as soon as possible after the date of injury or start of sickness. The most effective time for such notice is when the covered person has not been able to perform active work for 30 days.
4. Give us occupational data for all disabled covered persons. This includes, but is not limited to: (a) job descriptions and analyses; and (b) environmental factors.

Duties of Covered Persons and Beneficiaries: Your and your beneficiary's primary duties under the policy are listed below:

1. Give notice and proof of loss as soon as possible after the date of your injury or sickness, or the date of your death, or the death of a covered dependent, if applicable.
2. Give a complete account of the details of your injury or sickness or the death on a form approved by us.
3. Provide any other official documents to review the loss such as a certified death certificate, investigating officer's report, or medical records.
4. Allow release of medical and income data needed to adjudicate your claim.
5. Provide evidence of the regular care of a physician, if necessary.
6. Promptly report to us any changes in your status such as your address or telephone number, or if you return to work or are no longer disabled.
7. If benefits are overpaid, reimburse such overpayment within 60 days of the date benefits were overpaid.
8. Provide proof of your earnings for the period prior to a loss.

Fraud

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the policy and recovery of any amounts we have paid.

Accidental Death & Dismemberment Insurance

This section applies to the Voluntary Accidental Death & Dismemberment Benefit.

For Voluntary AD&D, you and any dependents covered under the Voluntary AD&D benefit are covered persons under this benefit.

If a covered person suffers a loss described below, we will pay the amount of insurance that applies. You or your beneficiary must give us proof that:

1. injury occurred while the insurance was in force under this section;
2. loss occurred within 365 days after the injury; and
3. loss was due to injury independent of all other causes.

Amount of Insurance

If a covered person suffers a specified loss, we will pay the benefit set opposite such loss; provided, however, that if the covered person sustains more than one such loss as the result of any one accident, we will pay only the one largest amount to which the covered person is entitled. In paying the benefit, we will consider only losses sustained while insured under this benefit.

Loss of Life .....100% of the AD&D Amount

Loss of Two or More Members.....100% of the AD&D Amount

Loss of One Member.....50% of the AD&D Amount

Loss of Thumb and Index Finger
of the Same Hand .....25% of the AD&D Amount

Member means hand, foot, sight, speech, or hearing.

Loss of sight means total and irrecoverable loss of sight.

Loss of hands or feet means total and irrecoverable loss due to severance at or above the wrist or ankle, unless the state in which the policy is issued defines the loss differently.

Loss of Thumb and Index Finger means total and irrecoverable loss at the proximal phalanx.

Loss of speech means a total and irrecoverable loss of audible communication.

Loss of hearing means permanent total deafness in both ears such that it cannot be corrected to any functional degree by any aid or device.

Exclusions

We will not pay a benefit for a loss caused directly or indirectly by:

1. disease, bodily or mental infirmity, or infection (except bacterial infection of a visible injury);
2. war or any act of war, or while serving in the armed forces of any country or international authority;
3. suicide or intentional, self-inflicted injury, whether sane or insane;
4. your active participation in a riot or insurrection;
5. your voluntary commission of, or attempting to commit, an assault or felony; or participating in an illegal occupation;
6. your voluntary use of any drug, hallucinogen, controlled substance, or narcotic unless taken as prescribed by a physician;

7. travel or flight in, or descent from, any aircraft unless as a fare paying passenger on a commercial airline flying between established airports on: (a) a scheduled route, or (b) a charter flight;
8. your being intoxicated as defined by the laws of the jurisdiction in which the accident occurred. Conviction is not necessary for a determination of being intoxicated.

Participation in a riot shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.

Riot shall include all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

War means declared or undeclared war or a conflict involving the armed forces of any country, group of countries, governments, or international organization.

Important Notice

The following information is provided to assist you in answering any questions you might have:

Soliciting Agent
The name, address and telephone number of our soliciting agent is available to you, if needed, by calling our Customer Service Department at [(800) 370-5856].

USAble Life

USAble Life
P. O. Box 1650
Little Rock, AR 72203-1650
Toll Free [(800) 370-5856]

If we fail to provide you with reasonable and adequate service, you may contact:

Arkansas Insurance Department

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Phone (501) 371-2640 or
Toll Free 1-800-852-5494

We appreciate the opportunity to serve your insurance needs.

ERISA Information

Plan Sponsorship and Administration

The plan was established by the actions of your employer, which continues to act as Plan Sponsor and Plan Administrator. Your employer, as Plan Administrator, performs the functions of distributing Plan notices and information to employees and other Plan participants, coordinates employees' and eligible dependents' enrollment in the Plan, and transmits Plan premium payments.

ERISA Rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.
4. Neither your employer, nor any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
5. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
6. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, provided that you have first followed the Plan's designated appeals procedure before bringing suit.
7. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees.
8. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
9. If you have any questions about your Plan, you should contact the Plan Administrator.
10. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

USAble Life

[320 W. Capitol] • P.O. Box 1650 • Little Rock, AR 72203-1650
[(501) 375-7200 • (800) 648-0271]

CERTIFICATE OF INSURANCE

Voluntary Accidental Death & Dismemberment

Policyholder: SIMMONS FIRST NATIONAL BANK

Class: 003 - BOARD OF DIRECTORS MEMBERS

State of Residence: ARKANSAS

This is to certify that USAble Life has issued and delivered the Insurance Policy to the Policyholder.

The policy insures the employees and their dependents, if elected, of the policyholder who:

1. eligible for the insurance;
2. become insured; and
3. continue to be insured;

according to the terms of the policy.

The terms of the policy that affect your insurance are contained in the following pages.

This Certificate of Insurance is a part of the policy. This certificate replaces any other that USAble Life may have issued to the policyholder to give to you under the Group Insurance Policy specified herein.

Signed for USAble Life:

James L. Tourse — Secretary

Jason Ram — President

Table of Contents

Schedule of Insurance

Policyholder: SIMMONS FIRST NATIONAL BANK

Group Policy Number: 50001328

Policy Effective Date: September 1, 2011*
*This certificate replaces any certificate issued before the date shown.

Eligible Class: Class 003 – BOARD OF DIRECTORS MEMBERS

Annual Enrollment Date: July 1 of each year

Full-time Employment: 30 hours weekly

Renewal Date: September 1, 2013

Waiting Period: You will be eligible for coverage on the first of the policy month following completion of the following period of continuous active work:

1. If you are working for the employer on the policy effective date – 0 days
2. If you start working for the employer after the policy effective date – 30 days

Benefits amounts for eligible employees shall be determined in accordance with the following schedule:

Benefit	Benefit Amount
Employee Voluntary Accidental Death & Dismemberment	The amount elected by you on your enrollment form. Elected in $10,000 increments up to a maximum of $500,000 or 5 times Basic Annual Salary, whichever is less.
Spouse Voluntary Accidental Death & Dismemberment	The amount elected by you on your enrollment form. Elected in $10,000 increments up to a maximum of $250,000.
Children Voluntary Accidental Death & Dismemberment	6 months and over: $5,000 or $10,000, as elected by you on your enrollment form. Age live birth to 6 months: $1,000
AD&D Coma Rider	5% per month for 11 months
AD&D Exposure & Disappearance Rider	AD&D benefit payable after 1 year of accidental disappearance
AD&D Repatriation Rider	10% up to $5,000
AD&D Seat Belt & Air Bag Rider	Seat Belt: 10% up to $10,000 Air Bag: 10% up to $10,000

Reductions, Terminations, and Special Provisions

Employee Voluntary Accidental Death & Dismemberment	Reduces to 65% at age 65 and to 50% at age 70. Terminates at retirement.
Spouse Voluntary Accidental Death & Dismemberment	Reduces to 65% at the spouse's age 65 and to 50% at the spouse's age 70. Terminates at retirement.

Definitions

The terms listed, if used, will have these meanings.

Accident or Injury mean accidental bodily injury sustained by the covered person while insured under the policy which is the direct cause of the loss, independent of disease or bodily infirmity or any other cause.

Active Work or Actively at Work mean the expenditure of time and energy for the policyholder or an associated company at your usual place of business on a full-time basis. If you are not working on a day your coverage would otherwise take effect, you will be considered to be at active work on that day only if:

1. when that work day begins, it would be reasonable to expect that you would be physically and mentally able to complete a full-time week of work in your regular occupation; and
2. you are not disabled; and
3. your contract of employment, if applicable, remains active; and
4. you are not on an unapproved, administrative or disciplinary leave; and
5. you return to work at the end of a paid break or vacation period.

Annual Enrollment Period means the 60 days prior to and the 30 days immediately following the Annual Enrollment Date shown in the Schedule of Insurance.

Annual Salary means your annual base rate of pay, excluding any overtime pay, bonuses, or other extra pay. If your pay is from commissions, your annual salary will be based on your average commissions for the prior 12 months.

Associated Company means any company shown in the application which is owned by or affiliated with the policyholder.

Beneficiary means the person or entity you choose to receive your amount of insurance at your death.

Contributory means you pay part of the premium.

Covered Person means an eligible employee or the employee's dependents whose insurance has become and remains effective under all the conditions and provisions of the policy. Covered persons do not include contract, temporary, seasonal, or part-time workers.

Dependent means an eligible person who is:

1. your spouse, if not legally separated from you;
2. any unmarried child less than age 25, who is:
   a. not working on a full-time basis, and
   b. depends upon you for more than 50% of his support; or
3. a handicapped child, as defined in the Continuation of Insurance for a Handicapped Child section, age 25 years or over, who was insured under this policy before reaching age 25.

The term "child" also includes a legally adopted child or child placed for adoption, stepchild, foster child, or any child who lives with you, and depends on you for more than 50% of his support.

Eligible Class means a class of persons eligible for insurance under the policy. This class is based on employment or membership in a group.

Eligible Persons means a person who:

1. is a citizen of the United States of America (U.S.) or Canada, who either:

a. resides in the U.S. or Canada; or
b. is stationed outside the U.S. or Canada for a period of less than 6 months; or

2. is a foreign national residing in the U.S. and meets all of the following requirements:
   a. has a valid permanent residency visa;
   b. participates in U.S. Social Security; and
   c. is covered by Workers' Compensation.

Employee means an eligible person who is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the policyholder or an associated company; or
4. a retiree, if listed as eligible in the policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the above conditions.

Employer means the policyholder.

Evidence of Insurability means a signed health and medical history form provided by us, a medical examination, if requested, and any additional information and attending physicians' statements that we may require.

Family Member means a person who is a parent, spouse, child, sibling, domestic partner, grandparent, grandchild, step-child, step-parent, step-sister, step-brother, father-in-law, or mother-in-law of the covered person; or spouses, as applicable, of any of these.

Full-time means working at least the number of hours indicated in the Schedule of Insurance for Full-time employment.

Gender – The use of the male pronoun also includes the female.

Home Office means the principal office of USAble Life in Little Rock, Arkansas.

Hospital means a facility supervised by one or more physicians and operated under state and local laws. It must have 24-hour nursing service by registered graduate nurses. It may specialize in treating alcoholism, drug addiction, chemical dependency, or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged.

Hospital Confined and Hospital Confinement mean staying in a hospital as a registered inpatient for 24 hours a day.

Material Duty or Material Duties mean the sets of tasks or skills required generally by employers from those engaged in an occupation. We will consider one material duty of your regular occupation to be the ability to work for an employer on a full-time basis as defined in the policy.

Noncontributory means the policyholder pays the premium.

Occupation means a group of jobs:

1. in which a common set of tasks is performed; or
2. which are related in terms of similar objectives and methodologies, and which may be related in terms of materials, products, worker actions, or worker characteristics.

Physician means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. This includes a person whom we are required to recognize as a physician by the laws or regulations of the governing jurisdiction. However, neither you nor a family member will be considered a physician.

Plan means the policy and certificates of insurance provided for covered persons.

Plan Administrator means the employer that sponsors the plan for the benefit of its employees and eligible dependents.

Policy means the group policy issued by us to the policyholder that describes the benefits for which you may be eligible.

Policyholder means the entity to which the policy is issued.

Regular Care means you personally visit a physician as often as is medically required to effectively manage and treat your disabling condition(s), according to generally accepted medical standards; and you are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the sickness or injury causing your disability must be given by a physician whose specialty or experience is appropriate.

Regular Occupation means the occupation in which you were working immediately prior to becoming disabled.

Retiree or Retirement means you begin receiving retirement benefits from either:

1. a retirement plan sponsored by your employer, the policyholder, or an associated company, or
2. a government plan.

Sickness means a disease or illness, including pregnancy.

United States of America means the fifty (50) states of the United States and the District of Columbia. It does not include territories of the United States.

Waiting Period is the number of continuous days of service during which you must be an active, full-time employee in a class eligible for insurance before you become eligible for coverage.

We, Us, and Our mean USAble Life.

You and Your mean an employee of the policyholder or an associated company who has met all the eligibility requirements for coverage, and is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the employer, or associated company covered under the policy; or
4. a retiree, if listed as eligible in the group Policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the conditions listed above.

Eligibility and Effective Date Provisions

Eligible Employee

If you are working on a full-time basis for the employer, you are eligible for insurance after completion of the required waiting period, provided you are in a class of employees who are included.

Employee Eligibility Date

If you are working for your employer in an eligible class, the date you are eligible for coverage is the latest of the following dates:

1. the policy effective date;
2. the day after you complete any waiting period shown in the Schedule of Insurance by continuous service with the employer, the policyholder, or an associated company;
3. the date the policy is changed to include your class; or
4. the date you become a member of a class eligible for insurance.

If you do not apply for voluntary coverage when you are first eligible, you will again be eligible on the first Annual Enrollment Date as shown in the Schedule of Insurance which immediately follows the date noted in items 2, 3, or 4 above.

Effective Date of Employee Insurance

You must use forms approved by us when applying for insurance.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When your Employer pays 100% of the cost of your coverage under the policy, you will be covered at 12:01 a.m. at your employer's address on your eligibility date.
2. When you and your Employer share the cost of your coverage under the policy or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. at your employer's address on the latest of the following dates:
   a. on your eligibility date, if you enroll for insurance within 31 days after the date you first become eligible for coverage; or
   b. on the first day of the policy month following the date we approve your application if you do not apply for insurance within 31 days after your eligibility date; or
   c. for voluntary coverage only, on the Annual Enrollment Date as shown in the Schedule of Insurance if you enroll during the annual enrollment period. If you do not apply for voluntary coverage during the first annual enrollment period following your eligibility date, you will be required to submit satisfactory evidence of insurability.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, your coverage will be effective on the first day of the policy month following the date we approve your application.

Delayed Effective Date

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, it will take effect on the day you return to active work. If your insurance is scheduled to take effect on a non-working day, your active work status will be based on the last working day before the scheduled effective date of your insurance.

Dependent Eligibility

Dependents are eligible for insurance on the latest of the following dates:

1. the date you become eligible for dependent insurance;
2. the date a person becomes a dependent; or

3. the date the policy is amended to include your class as being eligible for dependent insurance.

If you do not apply for voluntary dependent coverage when you are first eligible, you will again be eligible on the first Annual Enrollment Date as shown in the Schedule of Insurance which immediately follows the date noted in items 1, 2, or 3 above.

Your spouse or child will not be eligible for dependent insurance if either is insured under the policy as an employee.

If both you and your spouse are insured as employees, your eligible children may be insured as dependents of only one of you.

Effective Date of Dependent Insurance

You must use forms approved by us when applying for dependent insurance.

Dependents will not be insured until you are insured.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When your Employer pays 100% of the cost of your dependent coverage under the policy, your dependents will be covered at 12:01 a.m. at your employer's address on your dependent's eligibility date.
2. When you and your Employer share the cost of your dependent coverage under the policy or when you pay 100% of the cost yourself, your dependents will be covered at 12:01 a.m. at your employer's address on the latest of the following dates:
   a. on your dependent's eligibility date, if you enroll for dependent coverage within 31 days after the date your dependent first becomes eligible for coverage; or
   b. on the first day of the policy month following the date we approve your application for dependent coverage if you do not apply for dependent coverage within 31 days after your dependent's eligibility date; or
   c. for voluntary coverage only, on the Annual Enrollment Date as shown in the Schedule of Insurance if you enroll during the annual enrollment period. If you do not apply for voluntary dependent coverage during the first annual enrollment period following your dependent's eligibility date, you will be required to submit satisfactory evidence of insurability.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, your dependent's coverage will be effective on the first day of the policy month following the date we approve your application for dependent coverage.

You must furnish satisfactory evidence of the dependent's insurability at your own expense if you have previously terminated dependent coverage while in an eligible class.

Delayed Effective Date

Coverage for a dependent, other than a newborn child, who is confined in a hospital on the day dependent insurance or an increase in insurance is scheduled to take effect will not become effective until the 10th day following final discharge from the hospital.

Newborn Child Coverage (including children placed for adoption)

This section applies to the Voluntary Accidental Death & Dismemberment Benefit only.

Any child of yours born while this benefit is in force will be immediately covered as a dependent from the moment of birth for 90 days. Any newly adopted child or child placed for adoption will be immediately covered from the moment of placement for 90 days. In order for coverage to continue beyond 90 days we must receive: (1) written notice of the birth of the newborn child or

the date of placement for adoption; and (2) payment of any required additional premium within 31 days of our notifying the policyholder of the amount. Additional premium, if any, will begin on the premium due date following the child's date of birth or date of placement, if later.

Written notice should include the child's name, date of birth, and, if applicable, date placed for adoption. We must receive this notice by the end of the 90-day period following the date of birth or adoption placement. Notice is NOT required if you are already paying the premium for children's coverage.

If the required written notice is not received by us during the 90-day period, a newborn child or child placed for adoption may be covered after this date only if the following conditions are met: (1) your written application for coverage is approved by us; and (2) the payment of any required premium is made.

Changes in Coverage Provisions

When Coverage Amounts Change (Redetermination Date)

The policy redetermines your amount of insurance on the first of the policy month after a change occurs. If benefits are based on your salary, the policyholder must report updates to all covered person's earnings as they occur. Changes to a covered person's earnings are subject to any proof of insurability requirements of the policy. As of the policy's redetermination date, we use a covered person's salary or earnings on record with us to: (a) set rates; (b) set benefit amounts and limits; and (c) calculate premium payable under the policy.

Delayed Effective Date of Change

You must be actively at work on a full-time basis on the redetermination date. If you are not, your coverage amount will not change until the date you return to active work on a full-time basis. Changes in salary or earnings will not apply to a recurring disability.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

Changes to the Policy

Any increase or decrease in coverage because of a change in the plan of insurance will become effective on the date of the change. The Delayed Effective Date provision will apply to an increase.

Termination Provisions

Termination of Employee Insurance

Your insurance will terminate at 12:00 midnight on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date the policy terminates, or the date a specified benefit terminates;
3. the date you cease to be a member of a class eligible for insurance;
4. the date you cease to be actively at work.

Termination of Dependent Insurance

Insurance on a dependent will terminate at 12:00 midnight on the earliest of the following dates:

1. the date he ceases to be a dependent as defined in the Definitions section;
2. the date you cease to be an employee or a member of a class eligible for dependent insurance;
3. the last day of the period for which a required dependent premium payment is made, if the next payment is not made; or
4. the date the policy terminates, or a specific benefit terminates.

Continuation of Insurance for a Handicapped Dependent Child

If an unmarried dependent child is not capable of self-sustaining employment due to mental or physical handicap, his insurance will not terminate at age 25. The insurance will continue as long as the child remains handicapped, unless coverage terminates as described in the Termination of Dependent Insurance section, if you give us proof that the child is:

1. incapable of self-sustaining employment; and
2. chiefly dependent on you for support and maintenance.

To keep this coverage in force, we may require proof at our expense of the child's incapacity and dependence. We may require proof from time to time, but not more than once a year after the two years that follow the date the child reaches age 25.

Claim Provisions

Notice of Loss

Written notice of claim must be given to us at our Home Office within 30 days after a loss occurs or begins, or as soon after the loss as is reasonably possible to do so, but not later than one (1) year from the time notice is required. The notice should identify the covered person and the nature of the loss.

Within 15 days after the date of your notice, we will send you claim forms. The forms must be completed and sent to our Home Office. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.

Proof of Loss

For any loss for which the policy provides periodic payment contingent upon continuing loss, written proof of loss must be given to us within 90 days after the termination of the period for which we are liable. For any other loss covered by the policy, written proof of loss must be given to us within 90 days after the date of such loss. Failure to furnish proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time. Such proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof was otherwise required.

Physical Examination and Autopsy

We have the right to have a physician of our choice examine the covered person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.

Payment of Claims

All benefits payable under this policy will be payable immediately upon receipt of due written proof of such loss.

If included, Dismemberment benefits will be paid to you. Accidental Death benefits will be paid to the person(s) named by you to receive them.

If you failed to name a beneficiary or if no named beneficiary is living at your death, refer to the “Beneficiary” provision below. At our option, up to the maximum allowable by the state laws of the covered person’s state of residence may be paid to any person who incurred funeral or other expenses related to the last illness or death of the covered person.

Beneficiary

Your beneficiary will be the person(s) you name in writing to receive any amount of insurance payable due to your death. The beneficiary's name is on record in our Home Office, or in the policyholder's office if the group is self-administered. You are the beneficiary of the Dependent Life Insurance if you are living. If you and your dependent die in the same accident, the dependent benefit will be paid to your estate.

You may name or change a beneficiary by giving us written notice at our Home Office (or by giving the policyholder written notice if the group is self-administered) on a form acceptable to us. When we receive the notice, it will be effective on the date made, subject to any payment we may have made before we receive it.

If there is no named beneficiary living at your death, we may pay, at our discretion, any amount due to one of the following classes of survivors: (1) your spouse; (2) your surviving children in equal shares; (3) your mother and/or father; (4) your brother and/or sister; or (5) your estate.

Assignment

You may transfer your rights to name or change the beneficiary to someone else by assignment. An assignment will affect us only if it is in writing on a form acceptable to us, and is received at our Home Office. When we record it, the assignment will take effect as of the date you made it. The assignment will be subject to any action we may have taken before we record it. We take no responsibility for the validity of any assignment.

Claims of Creditors**:** To the extent allowed by law, proceeds will not be subject to any claims of a beneficiary's creditors.

Authority

The policyholder delegates to us and agrees that we have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the policy.

We decide: (a) if a covered person is eligible for this insurance; (b) if a covered person meets the requirements for benefits to be paid; and (c) what benefits are to be paid by the policy. We also interpret how the policy is to be administered. What we pay and the terms for payment are explained in this certificate.

Limit on Legal Action

No action at law or in equity may be brought against the policy until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations has expired, but, in any case, not after three (3) years from the date of loss.

Review Procedure

You must request, in writing, a review of a denial of your claim within 180 days after you receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit written comments, documents, records and other information relating to your claim for benefits.

We will review your claim after receiving your request and send you a notice of our decision within 45 days after we receive your request, or within 90 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant provisions of the policy. We will also advise you of your further appeal rights, if any.

Subrogation and Right of Reimbursement

The plan assumes and is subrogated to your legal rights to recover any payments the plan makes for benefits, when a covered sickness or injury resulted from the action or fault of a third party. The plan's subrogation rights include the right to recover the amount of benefits paid to you.

The plan has the right to recover any and all amounts equal to the plan's payments from:

1. the insurance of the injured party;
2. the person, company (or combination thereof) that caused the sickness or injury, or any insurance company; or
3. any other source, including disability benefit coverage.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The plan's recovery will not be reduced by your negligence, nor by attorney fees and costs you incur.

Priority Right of Reimbursement

Separate and apart from the plan's right of subrogation, the plan shall have first lien and right to reimbursement. This priority right of reimbursement supersedes your right to be made whole from any recovery, whether full or partial. You agree to reimburse the plan 100% first for any and all benefits provided through the plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

1. any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from your own insurance and/or from the third party (or their insurance);
2. any auto or recreational vehicle insurance coverage or benefits including, but not limited to disability benefit coverage; and
3. business and homeowner disability insurance coverage or payments.

The plan may notify those parties of its lien and right to reimbursement without notice to or consent from any covered person.

This priority right of reimbursement will not be reduced by attorney fees and costs you incur.

The plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available disability insurance coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

Notice and Cooperation

You are required to notify us promptly if you are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable us to protect the plan's rights under this section. You are also required to cooperate with us and to execute any documents that we, acting on behalf of the policyholder, deems necessary to protect the plan's rights under this section.

You shall not do anything to hinder, delay, impede or jeopardize the plan's subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the plan to withhold any and all benefits due you under the plan. This is in addition to any and all other rights that the plan has pursuant to the provisions of the plan's subrogation rights and/or priority right of reimbursement.

If the plan has to file suit, or otherwise litigate to enforce its subrogation rights and/or priority right of reimbursement, you are responsible for paying any and all costs, including attorneys' fees, the plan incurs in addition to the amounts recovered through the subrogation rights and/or priority right of reimbursement.

Legal Action and Costs

If a covered person settles any claim or action against any third party, that covered person shall be deemed to have been made whole by the settlement and the plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. The covered person shall hold any such proceeds of settlement or judgment in trust for the benefit of the plan. The plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the covered person in such circumstances.

Additionally, the plan has the right to sue on the covered person's behalf, against any person or entity considered responsible for any condition resulting in benefits paid or to be paid by the plan.

Settlement or Other Compromise

The covered person must notify the plan prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the plan's rights so that the plan may be present and protect its subrogation rights and/or priority right of reimbursement.

The plan's subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against the covered person.

The right of subrogation and the right of reimbursement are based on the plan language in effect at the time of judgment, payment, or settlement.

The plan, or its representative, may enforce the subrogation and priority right of reimbursement.

Alternate Dispute Resolution Procedures

This dispute resolution procedure ("procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all disputes with us. Such disputes include any matters that cause you to be dissatisfied with any aspect of your relationship with us, including any claim, controversy, or potential cause of action you may have against us. Please contact the Dispute Resolution office at (800) 648-0271 if you have any questions about this section of the certificate or to begin the dispute resolution process.

The following terms are applicable to all disputes:

1. This procedure is the exclusive method of resolving any disputes.
2. The procedure can only resolve disputes that are subject to our control.
3. This procedure will be governed by the Employee Retirement Income Security Act of 1974 ("ERISA"); Rules and Regulations for Administration and Enforcement; Claims Procedure (the "Claims Regulation"). That includes the definition of an adverse benefit determination, which is defined as any denial, reduction, termination or failure to provide or make payment for what you believe should be a covered benefit.
4. You may request a form from our Dispute Resolution office to authorize another person to act on your behalf concerning a dispute.
5. We may elect to skip one or more of the steps of this procedure if it is determined that step will not help to resolve the dispute.
6. Any dispute will be resolved in accordance with the terms of this certificate, applicable state or Federal laws and regulations.
7. You must begin the dispute process within 180 days from the date you receive notice of an adverse benefit determination. If you do not initiate the dispute process within that 180 day period, you give up the right to take any action based on that Dispute.

Description of the Procedure

Inquiry

You should contact our Dispute Resolution office to discuss and attempt to resolve any issues regarding a dispute. We hope that this informal process will resolve your questions or concerns.

Appeals

If you are not satisfied with the response to your inquiry, you may submit a written request (an "appeal") to the Office of the Appeals Coordinator, USAble Life, P.O. Box 1650, Little Rock, AR 72203-1650, asking that we reconsider an adverse benefit determination. Please contact the Dispute Resolution office if you have any questions about how to submit an appeal to us. You are not required to use a specific form, but you may request that the Dispute Resolution office send you a blank appeal form to ensure that you provide the information that will be needed to review your appeal.

We will assign a coordinator to review your appeal. The appeal coordinator is an individual with appropriate expertise who is neither the individual who made the adverse benefit determination, nor a subordinate of that individual.

The appeal coordinator may request that you submit additional information concerning your grievance. The appeal coordinator will also consider information submitted by others, including information requested from other USAble Life representatives. The appeal coordinator will have full discretionary authority to make eligibility, benefit or claim determinations and construe the terms of the policy. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the policy is not governed by ERISA.

We will make a decision within 60 days after receiving your appeal concerning a claim determination.

The appeal coordinator will send you a written decision concerning your appeal. The appeal coordinator's decision will include: a statement of the coordinator's understanding of your appeal; a statement explaining the basis of the decision; and a list of the documents or information upon which that decision was based. We will send you a copy of the listed documents, without charge, if you make a written request for such documents.

Post Appeal Procedure

If you are still not satisfied after completing the appeal procedure, you have the right to bring a civil action against us to obtain the remedies available pursuant to Sec. 502(a) of ERISA (an "ERISA Action") after completing the mandatory appeal process. Those ERISA remedies will apply to this policy even if your plan is not otherwise governed by ERISA. If you agree to arbitrate a dispute, we agree to suspend (or toll) any time periods affecting your right to bring an ERISA Action against us related to that dispute, until the arbitration has been completed.

You may request that the dispute be submitted for resolution by arbitration. That arbitration request must be submitted, in writing, to USAble Life's General Counsel within sixty (60) days after you receive the appeal coordinator's decision.

The dispute will be submitted to arbitration in accordance with the rules of the American Arbitration Association, unless we both agree to use an alternative dispute resolution administrator or procedure. The arbitration will be conducted before a single arbitrator.

We will pay the filing fee charged by the administrator and the arbitrator. You will be solely responsible for any other costs that you incur to participate in the arbitration process, including your attorney's fees. The filing fee and arbitrator's fees may be reallocated as part of an arbitration award, in whole or in part, at the discretion of the arbitrator.

The arbitration will be conducted in a location where it is reasonably convenient for you to participate. If we cannot agree concerning a convenient location, the administrator or arbitrator, if appointed, shall have the discretion to decide where the arbitration will be conducted.

The arbitrator: (a) shall consider the dispute individually and shall not certify or consider multiple disputes as part of a class action; (b) shall be required to issue a reasoned written decision explaining the basis of his or her decision and the manner of calculating any award; (c) shall limit his or her decision to deciding if our adverse benefit decision was arbitrary or capricious based on ERISA standards; (d) may not award punitive, extra-contractual, treble or exemplary damages unless permitted to do so by applicable statutes or regulations; (e) may not vary or disregard the terms of the policy; and (f) shall be bound by controlling law; when issuing a decision concerning the dispute.

The arbitrator shall limit discovery to the extent possible consistent with the objective of completing the arbitration in a fair, prompt, and cost effective manner. Emergency relief such as injunctive relief may be awarded by the arbitrator.

Contact Information

General Counsel
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: [(800) 648-0271]
Email: AppealCoordinator@usablelife.com

Office of the Dispute Resolution Coordinator
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: [(800) 648-0271]
Email: AppealCoordinator@usablelife.com

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General Provisions

Entire Contract

This certificate is furnished in accordance with and subject to the terms of the policy. The entire contract consists of the policy, which includes the application, any amendments and addenda; this certificate; your enrollment form, if required; and any riders or endorsements. No change in the policy will be effective until approved by one of our officers. This approval can only be in writing and must be noted on or attached to the policy. No agent has authority to change the policy or certificate or to waive any of their provisions.

Any statement made by you or the policyholder is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about you or the policyholder's plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

Incontestability

Unless the premiums have not been paid, the validity of the policy cannot be contested after it has been in force for two years.

Any statement made by the policyholder or a covered person will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the covered person or the beneficiary.

No statement, except fraudulent misstatement, made by a covered person about insurability will be used to deny a claim for a loss incurred or disability starting after coverage has been in effect for two years.

No claim for loss starting two or more years after the covered person's effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Agency

Neither the policyholder, any employer, any associated company, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

Unpaid Premium

We may deduct any unpaid premium then due from the payment of a claim under this certificate.

Refund of Premium

On the death of the covered person, proceeds payable hereunder shall include the amount of unearned premium paid beyond the end of the policy month in which death occurred. Payment shall be made in one lump sum no later than 30 days after proof of the covered person's death has been furnished to us.

Conformity with State Statutes

If the provisions of this certificate do not conform with the laws of the state in which you reside on the certificate effective date, they are hereby amended to conform with the minimum requirements of the statutes of that state.

Policy Management

Efficient management of the policy requires the joint efforts of the policyholder, USAble Life, and each covered person. Each party has certain duties to bring about the effective administration of the policy.

Duties of the Policyholder: The policyholder's primary duties under the policy are listed below.

1. Give us prompt, written notice of any change in business of the policyholder and employer. This includes, but is not limited to: (a) the type of business; (b) addition or deletion of an associated company; or (c) financial status due to bankruptcy; merger; acquisition; or dissolution.
2. Give us pertinent records for all covered persons. This includes, but is not limited to: (a) hire dates; (b) eligibility dates; (c) salaries; (d) occupations; and (e) birth dates. Give us updates of such records as needed.
3. Give us prompt notice of a covered person's disability. This notice should be given as soon as possible after the date of injury or start of sickness. The most effective time for such notice is when the covered person has not been able to perform active work for 30 days.
4. Give us occupational data for all disabled covered persons. This includes, but is not limited to: (a) job descriptions and analyses; and (b) environmental factors.

Duties of Covered Persons and Beneficiaries: Your and your beneficiary's primary duties under the policy are listed below:

1. Give notice and proof of loss as soon as possible after the date of your injury or sickness, or the date of your death, or the death of a covered dependent, if applicable.
2. Give a complete account of the details of your injury or sickness or the death on a form approved by us.
3. Provide any other official documents to review the loss such as a certified death certificate, investigating officer's report, or medical records.
4. Allow release of medical and income data needed to adjudicate your claim.
5. Provide evidence of the regular care of a physician, if necessary.
6. Promptly report to us any changes in your status such as your address or telephone number, or if you return to work or are no longer disabled.
7. If benefits are overpaid, reimburse such overpayment within 60 days of the date benefits were overpaid.
8. Provide proof of your earnings for the period prior to a loss.

Fraud

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the policy and recovery of any amounts we have paid.

Accidental Death & Dismemberment Insurance

This section applies to the Voluntary Accidental Death & Dismemberment Benefit.

For Voluntary AD&D, you and any dependents covered under the Voluntary AD&D benefit are covered persons under this benefit.

If a covered person suffers a loss described below, we will pay the amount of insurance that applies. You or your beneficiary must give us proof that:

1. injury occurred while the insurance was in force under this section;
2. loss occurred within 365 days after the injury; and
3. loss was due to injury independent of all other causes.

Amount of Insurance

If a covered person suffers a specified loss, we will pay the benefit set opposite such loss; provided, however, that if the covered person sustains more than one such loss as the result of any one accident, we will pay only the one largest amount to which the covered person is entitled. In paying the benefit, we will consider only losses sustained while insured under this benefit.

Loss of Life .....100% of the AD&D Amount

Loss of Two or More Members.....100% of the AD&D Amount

Loss of One Member.....50% of the AD&D Amount

Loss of Thumb and Index Finger
of the Same Hand .....25% of the AD&D Amount

Member means hand, foot, sight, speech, or hearing.

Loss of sight means total and irrecoverable loss of sight.

Loss of hands or feet means total and irrecoverable loss due to severance at or above the wrist or ankle, unless the state in which the policy is issued defines the loss differently.

Loss of Thumb and Index Finger means total and irrecoverable loss at the proximal phalanx.

Loss of speech means a total and irrecoverable loss of audible communication.

Loss of hearing means permanent total deafness in both ears such that it cannot be corrected to any functional degree by any aid or device.

Exclusions

We will not pay a benefit for a loss caused directly or indirectly by:

1. disease, bodily or mental infirmity, or infection (except bacterial infection of a visible injury);
2. war or any act of war, or while serving in the armed forces of any country or international authority;
3. suicide or intentional, self-inflicted injury, whether sane or insane;
4. your active participation in a riot or insurrection;
5. your voluntary commission of, or attempting to commit, an assault or felony; or participating in an illegal occupation;
6. your voluntary use of any drug, hallucinogen, controlled substance, or narcotic unless taken as prescribed by a physician;

7. travel or flight in, or descent from, any aircraft unless as a fare paying passenger on a commercial airline flying between established airports on: (a) a scheduled route, or (b) a charter flight;
8. your being intoxicated as defined by the laws of the jurisdiction in which the accident occurred. Conviction is not necessary for a determination of being intoxicated.

Participation in a riot shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.

Riot shall include all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

War means declared or undeclared war or a conflict involving the armed forces of any country, group of countries, governments, or international organization.

Important Notice

The following information is provided to assist you in answering any questions you might have:

Soliciting Agent
The name, address and telephone number of our soliciting agent is available to you, if needed, by calling our Customer Service Department at [(800) 370-5856].

USAble Life

USAble Life
P. O. Box 1650
Little Rock, AR 72203-1650
Toll Free [(800) 370-5856]

If we fail to provide you with reasonable and adequate service, you may contact:

Arkansas Insurance Department

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Phone (501) 371-2640 or
Toll Free 1-800-852-5494

We appreciate the opportunity to serve your insurance needs.

ERISA Information

Plan Sponsorship and Administration

The plan was established by the actions of your employer, which continues to act as Plan Sponsor and Plan Administrator. Your employer, as Plan Administrator, performs the functions of distributing Plan notices and information to employees and other Plan participants, coordinates employees' and eligible dependents' enrollment in the Plan, and transmits Plan premium payments.

ERISA Rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.
4. Neither your employer, nor any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
5. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
6. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, provided that you have first followed the Plan's designated appeals procedure before bringing suit.
7. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees.
8. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
9. If you have any questions about your Plan, you should contact the Plan Administrator.
10. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

USAble Life

[320 W. Capitol] • P.O. Box 1650 • Little Rock, AR 72203-1650
[(501) 375-7200 • (800) 648-0271]

CERTIFICATE OF INSURANCE

Voluntary Group Term Life

Policyholder: SIMMONS FIRST NATIONAL BANK

Class: 001 - SENIOR VICE PRESIDENTS AND ABOVE

State of Residence: ARKANSAS

This is to certify that USAble Life has issued and delivered the Insurance Policy to the Policyholder.

The policy insures the employees and their dependents, if elected, of the policyholder who:

1. eligible for the insurance;
2. become insured; and
3. continue to be insured;

according to the terms of the policy.

The terms of the policy that affect your insurance are contained in the following pages.

This Certificate of Insurance is a part of the policy. This certificate replaces any other that USAble Life may have issued to the policyholder to give to you under the Group Insurance Policy specified herein.

Signed for USAble Life:

James L. Tourse — Secretary

Jason Ram — President

Table of Contents

Schedule of Insurance

Policyholder: SIMMONS FIRST NATIONAL BANK

Group Policy Number: 50001328

Policy Effective Date: September 1, 2011*
*This certificate replaces any certificate issued before the date shown.

Eligible Class: Class 001 - SENIOR VICE PRESIDENTS AND ABOVE

Annual Enrollment Date: July 1 of each year

Full-time Employment: 30 hours weekly

Renewal Date: September 1, 2013

Waiting Period: You will be eligible for coverage on the first of the policy month following completion of the following period of continuous active work:

1. If you are working for the employer on the policy effective date – 0 days
2. If you start working for the employer after the policy effective date – 30 days

Benefits amounts for eligible employees shall be determined in accordance with the following schedule:

Benefit	Benefit Amount
Employee Voluntary Life	The amount elected by you on your enrollment form. Elected in $10,000 increments up to a maximum of $500,000 or 5 times Basic Annual Salary, whichever is less.
Life Insurance – Portability Option	Voluntary Life
Spouse Voluntary Dependent Life	The amount elected by you on your enrollment form. Elected in $10,000 increments up to a maximum of $250,000.
Children Voluntary Dependent Life	6 months and over: $5,000 or $10,000, as elected by you on your enrollment form. Age live birth to 6 months: $1,000
Group Life Accelerated Benefits	75% up to $250,000

If a covered person is eligible for any amount in excess of the guaranteed issue amount shown below, the employee must furnish evidence of insurability, which is subject to our approval.

Benefit	**Guaranteed Issue Amount**
Employee Voluntary Life	
Through age 69	$200,000
Age 70 and over	$0
Spouse Voluntary Dependent Life	$50,000
Through age 69	$0
Age 70 and over	
Children Voluntary Dependent Life	$10,000

Reductions, Terminations, and Special Provisions	
Employee Voluntary Life	Reduces to 65% at age 65 and to 50% at age 70. Terminates at retirement.
Spouse Voluntary Dependent Life	Reduces to 65% at the spouse's age 65 and to 50% at the spouse's age 70. Terminates at retirement.

Definitions

The terms listed, if used, will have these meanings.

Accident or Injury mean accidental bodily injury sustained by the covered person while insured under the policy which is the direct cause of the loss, independent of disease or bodily infirmity or any other cause.

Active Work or Actively at Work mean the expenditure of time and energy for the policyholder or an associated company at your usual place of business on a full-time basis. If you are not working on a day your coverage would otherwise take effect, you will be considered to be at active work on that day only if:

1. when that work day begins, it would be reasonable to expect that you would be physically and mentally able to complete a full-time week of work in your regular occupation; and
2. you are not disabled; and
3. your contract of employment, if applicable, remains active; and
4. you are not on an unapproved, administrative or disciplinary leave; and
5. you return to work at the end of a paid break or vacation period.

Annual Enrollment Period means the 60 days prior to and the 30 days immediately following the Annual Enrollment Date shown in the Schedule of Insurance.

Annual Salary means your annual base rate of pay, excluding any overtime pay, bonuses, or other extra pay. If your pay is from commissions, your annual salary will be based on your average commissions for the prior 12 months.

Associated Company means any company shown in the application which is owned by or affiliated with the policyholder.

Beneficiary means the person or entity you choose to receive your amount of insurance at your death.

Contributory means you pay part of the premium.

Covered Person means an eligible employee or the employee's dependents whose insurance has become and remains effective under all the conditions and provisions of the policy. Covered persons do not include contract, temporary, seasonal, or part-time workers.

Dependent means an eligible person who is:

1. your spouse, if not legally separated from you;
2. any unmarried child less than age 25, who is:
   a. not working on a full-time basis, and
   b. depends upon you for more than 50% of his support; or
3. a handicapped child, as defined in the Continuation of Insurance for a Handicapped Child section, age 25 years or over, who was insured under this policy before reaching age 25.

The term "child" also includes a legally adopted child or child placed for adoption, stepchild, foster child, or any child who lives with you, and depends on you for more than 50% of his support.

Eligible Class means a class of persons eligible for insurance under the policy. This class is based on employment or membership in a group.

Eligible Persons means a person who:

1. is a citizen of the United States of America (U.S.) or Canada, who either:

a. resides in the U.S. or Canada; or
b. is stationed outside the U.S. or Canada for a period of less than 6 months; or

2. is a foreign national residing in the U.S. and meets all of the following requirements:
   a. has a valid permanent residency visa;
   b. participates in U.S. Social Security; and
   c. is covered by Workers' Compensation.

Employee means an eligible person who is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the policyholder or an associated company; or
4. a retiree, if listed as eligible in the policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the above conditions.

Employer means the policyholder.

Evidence of Insurability means a signed health and medical history form provided by us, a medical examination, if requested, and any additional information and attending physicians' statements that we may require.

Family Member means a person who is a parent, spouse, child, sibling, domestic partner, grandparent, grandchild, step-child, step-parent, step-sister, step-brother, father-in-law, or mother-in-law of the covered person; or spouses, as applicable, of any of these.

Full-time means working at least the number of hours indicated in the Schedule of Insurance for Full-time employment.

Gender – The use of the male pronoun also includes the female.

Home Office means the principal office of USAble Life in Little Rock, Arkansas.

Hospital means a facility supervised by one or more physicians and operated under state and local laws. It must have 24-hour nursing service by registered graduate nurses. It may specialize in treating alcoholism, drug addiction, chemical dependency, or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged.

Hospital Confined and Hospital Confinement mean staying in a hospital as a registered inpatient for 24 hours a day.

Material Duty or Material Duties mean the sets of tasks or skills required generally by employers from those engaged in an occupation. We will consider one material duty of your regular occupation to be the ability to work for an employer on a full-time basis as defined in the policy.

Noncontributory means the policyholder pays the premium.

Occupation means a group of jobs:

1. in which a common set of tasks is performed; or
2. which are related in terms of similar objectives and methodologies, and which may be related in terms of materials, products, worker actions, or worker characteristics.

Physician means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. This includes a person whom we are required to recognize as a physician by the laws or regulations of the governing jurisdiction. However, neither you nor a family member will be considered a physician.

Plan means the policy and certificates of insurance provided for covered persons.

Plan Administrator means the employer that sponsors the plan for the benefit of its employees and eligible dependents.

Policy means the group policy issued by us to the policyholder that describes the benefits for which you may be eligible.

Policyholder means the entity to which the policy is issued.

Regular Care means you personally visit a physician as often as is medically required to effectively manage and treat your disabling condition(s), according to generally accepted medical standards; and you are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the sickness or injury causing your disability must be given by a physician whose specialty or experience is appropriate.

Regular Occupation means the occupation in which you were working immediately prior to becoming disabled.

Retiree or Retirement means you begin receiving retirement benefits from either:

1. a retirement plan sponsored by your employer, the policyholder, or an associated company, or
2. a government plan.

Sickness means a disease or illness, including pregnancy.

United States of America means the fifty (50) states of the United States and the District of Columbia. It does not include territories of the United States.

Waiting Period is the number of continuous days of service during which you must be an active, full-time employee in a class eligible for insurance before you become eligible for coverage.

We, Us, and Our mean USAble Life.

You and Your mean an employee of the policyholder or an associated company who has met all the eligibility requirements for coverage, and is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the employer, or associated company covered under the policy; or
4. a retiree, if listed as eligible in the group Policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the conditions listed above.

Eligibility and Effective Date Provisions

Eligible Employee

If you are working on a full-time basis for the employer, you are eligible for insurance after completion of the required waiting period, provided you are in a class of employees who are included.

Employee Eligibility Date

If you are working for your employer in an eligible class, the date you are eligible for coverage is the latest of the following dates:

1. the policy effective date;
2. the day after you complete any waiting period shown in the Schedule of Insurance by continuous service with the employer, the policyholder, or an associated company;
3. the date the policy is changed to include your class; or
4. the date you become a member of a class eligible for insurance.

If you do not apply for voluntary coverage when you are first eligible, you will again be eligible on the first Annual Enrollment Date as shown in the Schedule of Insurance which immediately follows the date noted in items 2, 3, or 4 above.

Effective Date of Employee Insurance

You must use forms approved by us when applying for insurance.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When your Employer pays 100% of the cost of your coverage under the policy, you will be covered at 12:01 a.m. at your employer's address on your eligibility date.
2. When you and your Employer share the cost of your coverage under the policy or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. at your employer's address on the latest of the following dates:
   a. on your eligibility date, if you enroll for insurance within 31 days after the date you first become eligible for coverage; or
   b. on the first day of the policy month following the date we approve your application if you do not apply for insurance within 31 days after your eligibility date; or
   c. for voluntary coverage only, on the Annual Enrollment Date as shown in the Schedule of Insurance if you enroll during the annual enrollment period. If you do not apply for voluntary coverage during the first annual enrollment period following your eligibility date, you will be required to submit satisfactory evidence of insurability.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, your coverage will be effective on the first day of the policy month following the date we approve your application.

Delayed Effective Date

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, it will take effect on the day you return to active work. If your insurance is scheduled to take effect on a non-working day, your active work status will be based on the last working day before the scheduled effective date of your insurance.

Dependent Eligibility

Dependents are eligible for insurance on the latest of the following dates:

1. the date you become eligible for dependent insurance;
2. the date a person becomes a dependent; or

3. the date the policy is amended to include your class as being eligible for dependent insurance.

If you do not apply for voluntary dependent coverage when you are first eligible, you will again be eligible on the first Annual Enrollment Date as shown in the Schedule of Insurance which immediately follows the date noted in items 1, 2, or 3 above.

Your spouse or child will not be eligible for dependent insurance if either is insured under the policy as an employee.

If both you and your spouse are insured as employees, your eligible children may be insured as dependents of only one of you.

Effective Date of Dependent Insurance

You must use forms approved by us when applying for dependent insurance.

Dependents will not be insured until you are insured.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When your Employer pays 100% of the cost of your dependent coverage under the policy, your dependents will be covered at 12:01 a.m. at your employer's address on your dependent's eligibility date.
2. When you and your Employer share the cost of your dependent coverage under the policy or when you pay 100% of the cost yourself, your dependents will be covered at 12:01 a.m. at your employer's address on the latest of the following dates:
   a. on your dependent's eligibility date, if you enroll for dependent coverage within 31 days after the date your dependent first becomes eligible for coverage; or
   b. on the first day of the policy month following the date we approve your application for dependent coverage if you do not apply for dependent coverage within 31 days after your dependent's eligibility date; or
   c. for voluntary coverage only, on the Annual Enrollment Date as shown in the Schedule of Insurance if you enroll during the annual enrollment period. If you do not apply for voluntary dependent coverage during the first annual enrollment period following your dependent's eligibility date, you will be required to submit satisfactory evidence of insurability.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, your dependent's coverage will be effective on the first day of the policy month following the date we approve your application for dependent coverage.

You must furnish satisfactory evidence of the dependent's insurability at your own expense if you have previously terminated dependent coverage while in an eligible class.

Delayed Effective Date

Coverage for a dependent, other than a newborn child, who is confined in a hospital on the day dependent insurance or an increase in insurance is scheduled to take effect will not become effective until the 10th day following final discharge from the hospital.

Changes in Coverage Provisions

When Coverage Amounts Change (Redetermination Date)

The policy redetermines your amount of insurance on the first of the policy month after a change occurs. If benefits are based on your salary, the policyholder must report updates to all covered person's earnings as they occur. Changes to a covered person's earnings are subject to any proof of insurability requirements of the policy. As of the policy's redetermination date, we use a covered person's salary or earnings on record with us to: (a) set rates; (b) set benefit amounts and limits; and (c) calculate premium payable under the policy.

Delayed Effective Date of Change

You must be actively at work on a full-time basis on the redetermination date. If you are not, your coverage amount will not change until the date you return to active work on a full-time basis. Changes in salary or earnings will not apply to a recurring disability.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

Changes to the Policy

Any increase or decrease in coverage because of a change in the plan of insurance will become effective on the date of the change. The Delayed Effective Date provision will apply to an increase.

Termination Provisions

Termination of Employee Insurance

Your insurance will terminate at 12:00 midnight on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date the policy terminates, or the date a specified benefit terminates;
3. the date you cease to be a member of a class eligible for insurance;
4. the date you cease to be actively at work;
5. if your coverage is continued under the Waiver of Premium provision, the date specified under "Termination of the Extended Insurance Benefit."

Continuation of Insurance

If you are unable to perform active work for a reason shown below, the policyholder may continue your insurance, except for any Accidental Death and Dismemberment coverage, on a premium-paying basis provided you remain in other respects a member of an eligible class. The continuance cannot be more than the maximum continuance shown below. The employer must act so as not to discriminate unfairly among employees in similar situations.

The maximum continuance for insurance is the longest applicable period described below:

1. six months following the date active work stopped due to lay-off or approved leave of absence, or
2. twelve months following the date active work stopped due to your total disability.

Total Disability for Continuation of Insurance means that you are under the regular care of a physician, and prevented by injury or sickness from performing all of the material duties of your regular occupation.

Termination of Dependent Insurance

Insurance on a dependent will terminate at 12:00 midnight on the earliest of the following dates:

1. the date he ceases to be a dependent as defined in the Definitions section;
2. the date you cease to be an employee or a member of a class eligible for dependent insurance;
3. the last day of the period for which a required dependent premium payment is made, if the next payment is not made; or
4. the date the policy terminates, or a specific benefit terminates.

Continuation of Insurance for a Handicapped Dependent Child

If an unmarried dependent child is not capable of self-sustaining employment due to mental or physical handicap, his insurance will not terminate at age 25. The insurance will continue as long as the child remains handicapped, unless coverage terminates as described in the Termination of Dependent Insurance section, if you give us proof that the child is:

1. incapable of self-sustaining employment; and
2. chiefly dependent on you for support and maintenance.

To keep this coverage in force, we may require proof at our expense of the child's incapacity and dependence. We may require proof from time to time, but not more than once a year after the two years that follow the date the child reaches age 25.

Claim Provisions

Notice of Loss

Written notice of claim must be given to us at our Home Office within 30 days after a loss occurs or begins, or as soon after the loss as is reasonably possible to do so, but not later than one (1) year from the time notice is required. The notice should identify the covered person and the nature of the loss.

Within 15 days after the date of your notice, we will send you claim forms. The forms must be completed and sent to our Home Office. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.

Proof of Loss

For any loss for which the policy provides periodic payment contingent upon continuing loss, written proof of loss must be given to us within 90 days after the termination of the period for which we are liable. For any other loss covered by the policy, written proof of loss must be given to us within 90 days after the date of such loss. Failure to furnish proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time. Such proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof was otherwise required.

Physical Examination and Autopsy

We have the right to have a physician of our choice examine the covered person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.

Payment of Claims

All benefits payable under this policy will be payable immediately upon receipt of due written proof of such loss.

If included, Dependent Life benefits will be paid to you. Employee Life insurance benefits will be paid to the person(s) named by you to receive them.

If you failed to name a beneficiary or if no named beneficiary is living at your death, refer to the “Beneficiary” provision below. At our option, up to the maximum allowable by the state laws of the covered person’s state of residence may be paid to any person who incurred funeral or other expenses related to the last illness or death of the covered person.

Beneficiary

Your beneficiary will be the person(s) you name in writing to receive any amount of insurance payable due to your death. The beneficiary's name is on record in our Home Office, or in the policyholder's office if the group is self-administered. You are the beneficiary of the Dependent Life Insurance if you are living. If you and your dependent die in the same accident, the dependent benefit will be paid to your estate.

You may name or change a beneficiary by giving us written notice at our Home Office (or by giving the policyholder written notice if the group is self-administered) on a form acceptable to us. When we receive the notice, it will be effective on the date made, subject to any payment we may have made before we receive it.

If there is no named beneficiary living at your death, we may pay, at our discretion, any amount due to one of the following classes of survivors: (1) your spouse; (2) your surviving children in equal shares; (3) your mother and/or father; (4) your brother and/or sister; or (5) your estate.

Assignment

You may transfer your rights to name or change the beneficiary to someone else by assignment. An assignment will affect us only if it is in writing on a form acceptable to us, and is received at our Home Office. When we record it, the assignment will take effect as of the date you made it. The assignment will be subject to any action we may have taken before we record it. We take no responsibility for the validity of any assignment.

Claims of Creditors**:** To the extent allowed by law, proceeds will not be subject to any claims of a beneficiary's creditors.

Authority

The policyholder delegates to us and agrees that we have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the policy.

We decide: (a) if a covered person is eligible for this insurance; (b) if a covered person meets the requirements for benefits to be paid; and (c) what benefits are to be paid by the policy. We also interpret how the policy is to be administered. What we pay and the terms for payment are explained in this certificate.

Limit on Legal Action

No action at law or in equity may be brought against the policy until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations has expired, but, in any case, not after three (3) years from the date of loss.

Review Procedure

You must request, in writing, a review of a denial of your claim within 180 days after you receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit written comments, documents, records and other information relating to your claim for benefits.

We will review your claim after receiving your request and send you a notice of our decision within 45 days after we receive your request, or within 90 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant provisions of the policy. We will also advise you of your further appeal rights, if any.

Subrogation and Right of Reimbursement

The plan assumes and is subrogated to your legal rights to recover any payments the plan makes for benefits, when a covered sickness or injury resulted from the action or fault of a third party. The plan's subrogation rights include the right to recover the amount of benefits paid to you.

The plan has the right to recover any and all amounts equal to the plan's payments from:

1. the insurance of the injured party;
2. the person, company (or combination thereof) that caused the sickness or injury, or any insurance company; or
3. any other source, including disability benefit coverage.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The plan's recovery will not be reduced by your negligence, nor by attorney fees and costs you incur.

Priority Right of Reimbursement

Separate and apart from the plan's right of subrogation, the plan shall have first lien and right to reimbursement. This priority right of reimbursement supersedes your right to be made whole from any recovery, whether full or partial. You agree to reimburse the plan 100% first for any and all benefits provided through the plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

1. any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from your own insurance and/or from the third party (or their insurance);
2. any auto or recreational vehicle insurance coverage or benefits including, but not limited to disability benefit coverage; and
3. business and homeowner disability insurance coverage or payments.

The plan may notify those parties of its lien and right to reimbursement without notice to or consent from any covered person.

This priority right of reimbursement will not be reduced by attorney fees and costs you incur.

The plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available disability insurance coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

Notice and Cooperation

You are required to notify us promptly if you are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable us to protect the plan's rights under this section. You are also required to cooperate with us and to execute any documents that we, acting on behalf of the policyholder, deems necessary to protect the plan's rights under this section.

You shall not do anything to hinder, delay, impede or jeopardize the plan's subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the plan to withhold any and all benefits due you under the plan. This is in addition to any and all other rights that the plan has pursuant to the provisions of the plan's subrogation rights and/or priority right of reimbursement.

If the plan has to file suit, or otherwise litigate to enforce its subrogation rights and/or priority right of reimbursement, you are responsible for paying any and all costs, including attorneys' fees, the plan incurs in addition to the amounts recovered through the subrogation rights and/or priority right of reimbursement.

Legal Action and Costs

If a covered person settles any claim or action against any third party, that covered person shall be deemed to have been made whole by the settlement and the plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. The covered person shall hold any such proceeds of settlement or judgment in trust for the benefit of the plan. The plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the covered person in such circumstances.

Additionally, the plan has the right to sue on the covered person's behalf, against any person or entity considered responsible for any condition resulting in benefits paid or to be paid by the plan.

Settlement or Other Compromise

The covered person must notify the plan prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the plan's rights so that the plan may be present and protect its subrogation rights and/or priority right of reimbursement.

The plan's subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against the covered person.

The right of subrogation and the right of reimbursement are based on the plan language in effect at the time of judgment, payment, or settlement.

The plan, or its representative, may enforce the subrogation and priority right of reimbursement.

Alternate Dispute Resolution Procedures

This dispute resolution procedure ("procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all disputes with us. Such disputes include any matters that cause you to be dissatisfied with any aspect of your relationship with us, including any claim, controversy, or potential cause of action you may have against us. Please contact the Dispute Resolution office at (800) 648-0271 if you have any questions about this section of the certificate or to begin the dispute resolution process.

The following terms are applicable to all disputes:

1. This procedure is the exclusive method of resolving any disputes.
2. The procedure can only resolve disputes that are subject to our control.
3. This procedure will be governed by the Employee Retirement Income Security Act of 1974 ("ERISA"); Rules and Regulations for Administration and Enforcement; Claims Procedure (the "Claims Regulation"). That includes the definition of an adverse benefit determination, which is defined as any denial, reduction, termination or failure to provide or make payment for what you believe should be a covered benefit.
4. You may request a form from our Dispute Resolution office to authorize another person to act on your behalf concerning a dispute.
5. We may elect to skip one or more of the steps of this procedure if it is determined that step will not help to resolve the dispute.
6. Any dispute will be resolved in accordance with the terms of this certificate, applicable state or Federal laws and regulations.
7. You must begin the dispute process within 180 days from the date you receive notice of an adverse benefit determination. If you do not initiate the dispute process within that 180 day period, you give up the right to take any action based on that Dispute.

Description of the Procedure

Inquiry

You should contact our Dispute Resolution office to discuss and attempt to resolve any issues regarding a dispute. We hope that this informal process will resolve your questions or concerns.

Appeals

If you are not satisfied with the response to your inquiry, you may submit a written request (an "appeal") to the Office of the Appeals Coordinator, USAble Life, P.O. Box 1650, Little Rock, AR 72203-1650, asking that we reconsider an adverse benefit determination. Please contact the Dispute Resolution office if you have any questions about how to submit an appeal to us. You are not required to use a specific form, but you may request that the Dispute Resolution office send you a blank appeal form to ensure that you provide the information that will be needed to review your appeal.

We will assign a coordinator to review your appeal. The appeal coordinator is an individual with appropriate expertise who is neither the individual who made the adverse benefit determination, nor a subordinate of that individual.

The appeal coordinator may request that you submit additional information concerning your grievance. The appeal coordinator will also consider information submitted by others, including information requested from other USAble Life representatives. The appeal coordinator will have full discretionary authority to make eligibility, benefit or claim determinations and construe the terms of the policy. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the policy is not governed by ERISA.

We will make a decision within 60 days after receiving your appeal concerning a claim determination.

The appeal coordinator will send you a written decision concerning your appeal. The appeal coordinator's decision will include: a statement of the coordinator's understanding of your appeal; a statement explaining the basis of the decision; and a list of the documents or information upon which that decision was based. We will send you a copy of the listed documents, without charge, if you make a written request for such documents.

Post Appeal Procedure

If you are still not satisfied after completing the appeal procedure, you have the right to bring a civil action against us to obtain the remedies available pursuant to Sec. 502(a) of ERISA (an "ERISA Action") after completing the mandatory appeal process. Those ERISA remedies will apply to this policy even if your plan is not otherwise governed by ERISA. If you agree to arbitrate a dispute, we agree to suspend (or toll) any time periods affecting your right to bring an ERISA Action against us related to that dispute, until the arbitration has been completed.

You may request that the dispute be submitted for resolution by arbitration. That arbitration request must be submitted, in writing, to USAble Life's General Counsel within sixty (60) days after you receive the appeal coordinator's decision.

The dispute will be submitted to arbitration in accordance with the rules of the American Arbitration Association, unless we both agree to use an alternative dispute resolution administrator or procedure. The arbitration will be conducted before a single arbitrator.

We will pay the filing fee charged by the administrator and the arbitrator. You will be solely responsible for any other costs that you incur to participate in the arbitration process, including your attorney's fees. The filing fee and arbitrator's fees may be reallocated as part of an arbitration award, in whole or in part, at the discretion of the arbitrator.

The arbitration will be conducted in a location where it is reasonably convenient for you to participate. If we cannot agree concerning a convenient location, the administrator or arbitrator, if appointed, shall have the discretion to decide where the arbitration will be conducted.

The arbitrator: (a) shall consider the dispute individually and shall not certify or consider multiple disputes as part of a class action; (b) shall be required to issue a reasoned written decision explaining the basis of his or her decision and the manner of calculating any award; (c) shall limit his or her decision to deciding if our adverse benefit decision was arbitrary or capricious based on ERISA standards; (d) may not award punitive, extra-contractual, treble or exemplary damages unless permitted to do so by applicable statutes or regulations; (e) may not vary or disregard the terms of the policy; and (f) shall be bound by controlling law; when issuing a decision concerning the dispute.

The arbitrator shall limit discovery to the extent possible consistent with the objective of completing the arbitration in a fair, prompt, and cost effective manner. Emergency relief such as injunctive relief may be awarded by the arbitrator.

Contact Information

General Counsel
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: [(800) 648-0271]
Email: AppealCoordinator@usablelife.com

Office of the Dispute Resolution Coordinator
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: [(800) 648-0271]
Email: AppealCoordinator@usablelife.com

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General Provisions

Entire Contract

This certificate is furnished in accordance with and subject to the terms of the policy. The entire contract consists of the policy, which includes the application, any amendments and addenda; this certificate; your enrollment form, if required; and any riders or endorsements. No change in the policy will be effective until approved by one of our officers. This approval can only be in writing and must be noted on or attached to the policy. No agent has authority to change the policy or certificate or to waive any of their provisions.

Any statement made by you or the policyholder is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about you or the policyholder's plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

Incontestability

Unless the premiums have not been paid, the validity of the policy cannot be contested after it has been in force for two years.

Any statement made by the policyholder or a covered person will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the covered person or the beneficiary.

No statement, except fraudulent misstatement, made by a covered person about insurability will be used to deny a claim for a loss incurred or disability starting after coverage has been in effect for two years.

No claim for loss starting two or more years after the covered person's effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Agency

Neither the policyholder, any employer, any associated company, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

Unpaid Premium

We may deduct any unpaid premium then due from the payment of a claim under this certificate.

Refund of Premium

On the death of the covered person, proceeds payable hereunder shall include the amount of unearned premium paid beyond the end of the policy month in which death occurred. Payment shall be made in one lump sum no later than 30 days after proof of the covered person's death has been furnished to us.

Conformity with State Statutes

If the provisions of this certificate do not conform with the laws of the state in which you reside on the certificate effective date, they are hereby amended to conform with the minimum requirements of the statutes of that state.

Policy Management

Efficient management of the policy requires the joint efforts of the policyholder, USAble Life, and each covered person. Each party has certain duties to bring about the effective administration of the policy.

Duties of the Policyholder: The policyholder's primary duties under the policy are listed below.

1. Give us prompt, written notice of any change in business of the policyholder and employer. This includes, but is not limited to: (a) the type of business; (b) addition or deletion of an associated company; or (c) financial status due to bankruptcy; merger; acquisition; or dissolution.
2. Give us pertinent records for all covered persons. This includes, but is not limited to: (a) hire dates; (b) eligibility dates; (c) salaries; (d) occupations; and (e) birth dates. Give us updates of such records as needed.
3. Give us prompt notice of a covered person's disability. This notice should be given as soon as possible after the date of injury or start of sickness. The most effective time for such notice is when the covered person has not been able to perform active work for 30 days.
4. Give us occupational data for all disabled covered persons. This includes, but is not limited to: (a) job descriptions and analyses; and (b) environmental factors.

Duties of Covered Persons and Beneficiaries: Your and your beneficiary's primary duties under the policy are listed below:

1. Give notice and proof of loss as soon as possible after the date of your injury or sickness, or the date of your death, or the death of a covered dependent, if applicable.
2. Give a complete account of the details of your injury or sickness or the death on a form approved by us.
3. Provide any other official documents to review the loss such as a certified death certificate, investigating officer's report, or medical records.
4. Allow release of medical and income data needed to adjudicate your claim.
5. Provide evidence of the regular care of a physician, if necessary.
6. Promptly report to us any changes in your status such as your address or telephone number, or if you return to work or are no longer disabled.
7. If benefits are overpaid, reimburse such overpayment within 60 days of the date benefits were overpaid.
8. Provide proof of your earnings for the period prior to a loss.

Fraud

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the policy and recovery of any amounts we have paid.

Employee Term Life Insurance

Death Benefit

We will pay your beneficiary the amount of insurance in force on the date of death, as shown in the Schedule of Insurance, when we receive all required proof of loss, including written proof of your death acceptable to us and a completed claim form.

Suicide

This provision applies to Voluntary Life only. If you, whether sane or insane, die by suicide within one year(s) of your original effective date of insurance, the death benefit will be limited to the amount of premiums paid for your insurance.

After having been insured for one year(s), if you, whether sane or insane, die by suicide within one year(s) of the effective date of an increase in coverage, the death benefit will be limited to the amount of insurance in effect prior to the increase in coverage, plus the amount of premiums paid for the increase in coverage.

With respect to employees insured on the effective date of the policy:

1. if the policy replaces another group life policy, the one year(s) limitation on death by suicide shall be reduced by the number of months you were continuously insured by the prior policy; and
2. the benefit payable shall be the lesser of the amount otherwise payable under this policy or the amount provided by the prior policy.

Conversion Privilege for Life Insurance

Conversion upon Termination of Employment or Eligibility

For Employees

You may convert all or part of your life insurance to an individual policy of life insurance, other than Term,

1. if all or part of it stops for any reason; unless
2. it stops because you did not pay any required premiums.

The amount you may apply for may not be more than:

1. the life amount then in force; or
2. that part of the life amount which has stopped, whichever is less.

Accidental death and dismemberment, disability or any other supplemental coverage for which you are eligible under this policy may not be converted.

For Dependents

Your covered dependent spouse or child may convert all or part of his life insurance to an individual life policy, other than Term, if the insurance on his life ends because:

1. you stopped working full-time for your employer; or
2. you ceased to be a member of a class eligible for insurance; or
3. the dependent ceased to be an eligible family member; or
4. of your death.

Conversion upon Termination or Amendment of Group Policy

Any covered person may convert a limited amount of life insurance if he has been continuously insured under the policy for at least five (5) years and his insurance ends due to termination or amendment of the policy.

The amount you may convert in this case is the smaller of the following:

1. the amount of life insurance which terminates, less the amount you became eligible for under any group policy within 31 days after this insurance terminated; or
2. $10,000.

Conversion Coverage

Any covered person may convert his life insurance to any policy we are issuing for the purpose of conversions other than Term. The conversion policy will not have disability or other supplementary benefits. No evidence of insurability will be required. The premium will be based on the amount and the form of the conversion policy, and on the covered person's class of risk and age on the date the conversion takes effect.

A conversion policy is in lieu of all other benefits under this policy. If you qualify for the Extended Insurance Benefit, any conversion policy issued will be canceled. Premiums paid for the converted policy will be returned.

The conversion policy will take effect on the 32nd day after the insurance terminates.

Notice and Application Required

Written application and the first premium payment for the conversion policy must be received in our Home Office within 31 days after the covered person's insurance terminates. If you are not given notice of the right to convert by the 16th day of the 31 day conversion period, you will have an additional period in which to apply for conversion. The additional period will end 15

days after you are given notice, but not more than 61 days after the date the insurance under the policy ended.

Nothing in the policy will continue coverage for more than 31 days following the date coverage ends under the policy. Written notice, contained in this certificate of insurance and given to you at any time, or mailed by the policyholder to your last known address will be considered sufficient written notice to you. It is the responsibility of the policyholder to give such notice to you.

Conversion Period Death Benefit

If the covered person dies within the 31 days allowed for making application to convert, we will pay the amount he was entitled to convert. We will do this whether or not application was made.

Life Insurance – Waiver of Premium

This section applies to the Voluntary Life Insurance Benefit only.

Extended Insurance Benefit (Waiver of Premium)

We will continue the term life insurance in force on you and your covered dependents without premium payment if you become totally disabled provided:

1. you are insured under this plan and are actively at work on or after the effective date of the plan; and
2. your total disability begins before age 70; and
3. you provide us with proof of total disability as required; and
4. you are still totally disabled when you submit the proof of disability.

Dependent premiums will only be waived if the employee is also covered and his premiums are waived.

Amount of Life Insurance

The amount of life insurance continued will be the amount in force on the date you became totally disabled. This amount will be reduced or terminated based on the Schedule of Insurance in effect on the date of total disability. This amount will not be increased while you remain totally disabled.

Definition of Total Disability

For the purposes of waiver of premium, "total disability" or "totally disabled" means that you are under the regular care of a physician, and prevented by injury or physical or mental sickness from performing the material duties of any gainful occupation.

Gainful Occupation means any employment that exists in the national economy that you may be expected to follow based on your education, training, experience, age, and physical and mental capacity, and from which you are expected to earn at least 80% of your pre-disability earnings within 12 months of your return to active work.

Proof of Total Disability

Upon receipt of Notice of Loss, we will provide forms which you must use when giving us proof of total disability. (See "Notice of Loss" under the Claim Provisions.) You must give us proof no later than 12 months after the date you became totally disabled. We may at any time require proof that total disability continues. You must give us proof of continuing disability within 60 days after our request. After you have been totally disabled for more than two years from the date of total disability, we will not request proof more than once a year. We may require that you be examined at our expense by a physician of our choice.

Death While Totally Disabled

If you die while your life insurance is being continued under this provision, we will pay the amount of insurance if we receive proof:

1. of your death; and
2. that total disability was continuous from the date it began to the date of death.

Termination of the Extended Insurance Benefit

You will no longer be eligible for the Extended Insurance Benefit and your life insurance will terminate on the earliest of the following dates:

1. the date you cease to be totally disabled. But, if you are still eligible for life insurance when you return to active work, your life insurance may be continued in force if premium payments are resumed. If this is done, any increased amount of life insurance you may then be eligible for will take effect as described in the Effective Date of Insurance provision; or
2. the last day of the 60 day period following our request for proof of total disability, if you do not give us proof or you refuse to take a medical exam; or
3. the date you attain age 70.

If your life insurance terminates while you are covered under this provision, you will be eligible to convert that coverage as of the termination date. You may convert no more than the amount of term life insurance that was in force on you on that date. (See "Conversion Privilege for Life Insurance" provision.)

Termination of the Extended Insurance Benefit for the Covered Dependent

Your covered dependent will no longer be eligible for the Extended Insurance Benefit and the dependent's life insurance will terminate on the earliest of the following dates:

1. the date the dependent ceases to be a dependent as defined in the Definition section; or
2. the date you cease to be eligible for coverage under the Extended Insurance Benefit (Waiver of Premium) provision. But, if the dependent is still eligible for dependent life insurance when you return to active work, the dependent life insurance may be continued in force if premium payments are resumed. If this is done, any increased amount of dependent life insurance the dependent may then be eligible for will take effect as described in the Effective Date of Dependent Insurance provision; or
3. 12 months from the date your total disability began.

Your covered dependent whose insurance terminates while covered under this provision will be eligible to convert that coverage as of the termination date. He may convert no more than the amount of dependent life insurance that was in force on that date. (See "Conversion Privilege for Life Insurance" provision.)

Life Insurance – Portability

This section applies to the Voluntary Life Insurance Benefit only.

Portability Benefit

You may continue your and your spouse's voluntary term life insurance if your employment terminates and you meet the following requirements on the date your employment terminates:

1. you are not disabled; and
2. you either:
   a. are not retired and are under age 70; or
   b. you are retired and are under age 65.

Coverage will be continued under the policy for employees who elect continuation of coverage under this portability provision. Portability is not available upon policy cancellation.

Your spouse's term life insurance may not be continued if your term life insurance is not continued. Dependent children are not eligible for the Portability provision; however, the dependent children's coverage may be converted under the "Conversion Privilege" provisions of the policy.

"Retired" means you are a former employee who has begun receiving one of the following:

1. retirement pension benefits under any plan of a federal, state, county or municipal retirement system, if such pension benefits include any credit for employment with the policyholder;
2. retirement pension benefits under any plan which the policyholder sponsors or makes or has made contributions; or
3. retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act.

Application and Premium Payment

You must apply for portability in writing to USAble Life within 31 days after the date your employment ends.

You must pay the required premium quarterly, semi-annually, or annually directly to USAble Life. The premium rate will be determined by us. The first premium payment must be made no later than 31 days after the date the insurance would otherwise terminate under the policy.

Amount of Insurance

The amount of insurance that you and your spouse may continue is the amount in effect on the date your employment terminates. The reduction and termination provisions stated in the Change Rider – Portability will apply to insurance continued under this provision.

When Portability Ends

Your continued coverage under this provision will end automatically on the earliest of the following:

1. the date the last period ends for which you made a premium payment;
2. the premium due date after the covered person has continued coverage under this provision for 3 year(s);
3. the premium due date following your attainment of age 70;
4. if your coverage continued due to your retirement prior to age 65, on the premium due date following your attainment of age 65;
5. the date you become a full-time member of the armed forces of any country; or

6. spouse coverage will end on the premium due date following the date the spouse ceases to be a dependent as defined in the policy, or
7. spouse coverage will end on the premium due date following the spouse's attainment of age 65.

When your insurance under the portability provision ends, you and your spouse will be eligible to convert your insurance to an individual policy under the "Conversion Privilege" provisions.

Coverage continued under the portability provision is in lieu of all other benefits under the policy, including conversion. If you return to work with the employer and again become eligible for Term Life coverage under the policy, continued coverage under the portability provision will cancel on the date coverage is resumed under the policy.

Other Policy Provisions

The Life Insurance – Waiver of Premium and the Group Life Accelerated Benefit provisions will not apply to insurance continued under the Portability provision.

With respect to any notice you are required to provide to the employer under other provisions of the policy, you must provide such notice to USAble Life while the insurance is continued under the Portability provision.

Dependent Term Life Insurance

Death Benefit

We will pay the amount of insurance in force on the date of death, as shown in the Schedule of Insurance, when we receive all required proof of loss, including written proof of your covered dependent's death acceptable to us and a completed claim form.

Suicide

If a covered dependent, whether sane or insane, dies by suicide within one year(s) of his original effective date of insurance, the death benefit will be limited to the amount of premiums paid for this insurance.

After having been insured for one year(s), if a covered dependent, whether sane or insane, dies by suicide within one year(s) of the effective date of an increase in coverage, the death benefit will be limited to the amount of insurance in effect prior to the increase in coverage, plus the amount of premiums paid for the increase in coverage.

With respect to dependents insured on the effective date of the policy:

1. if the policy replaces another group life policy providing similar dependent life insurance, the one year(s) limitation on death by suicide shall be reduced by the number of months you were continuously insured for dependent life by the prior policy; and
2. the benefit payable shall be the lesser of the amount otherwise payable under this policy or the amount provided by the prior policy.

Group Life Accelerated Benefit

This section applies to the Voluntary Life Insurance Benefit only.

Notice of Possible Tax Consequences

Please be advised that receipt of the accelerated benefits may be taxable. Any person who receives accelerated benefits should consult his personal tax advisor.

The receipt of accelerated benefit payments may adversely affect the covered person's eligibility for Medicaid or other government benefits or entitlements.

Definitions

"Terminal Illness" means a medical condition:

1. which is expected to result in the covered person's death within 12 months; and
2. from which the covered person is not expected to recover.

Eligibility

All covered employees and covered dependents under age 70 who are insured for a minimum of $10,000 of life insurance under the policy are eligible.

A covered employee or dependent is eligible for the accelerated benefit only if he becomes and remains insured for life insurance under the policy.

Accelerated Benefit

The accelerated benefit is an advance payment to the covered person who:

1. is terminally ill; and
2. elects to receive part of his life insurance benefit payable under the group policy, subject to the maximum benefit amounts stated on the Schedule of Insurance.

We will pay an accelerated benefit to you when we receive the following:

1. a written request for payment of the accelerated benefit; and
2. proof that the covered person is terminally ill and his illness is expected to result in his death within 12 months.

The accelerated benefit will be paid only once for each eligible covered person, and in one lump sum to you before death occurs.

Cost of Providing the Accelerated Benefit

There is no cost associated with providing the accelerated benefit.

Amount of Accelerated Benefit

The maximum accelerated benefit will be the lesser of:

1. 75% of the covered person's life insurance amount; or
2. $250,000.

If the covered person's life insurance amount is scheduled for a reduction within 12 months after the date you request the payment of the accelerated benefit, the maximum accelerated benefit will be based on the reduced amount.

Irrevocable Beneficiary

For the purpose of the Accelerated Benefit provision, an irrevocable beneficiary is a named beneficiary whose rights to the employee's life insurance proceeds are vested and whose rights cannot be cancelled by the employee unless the irrevocable beneficiary consents.

Conditions and Requirements for Payment of the Accelerated Benefit

You must request payment of an accelerated benefit in writing.

Proof that the covered person is terminally ill must be provided to us. The proof must be certified by a licensed physician and in a form that is satisfactory to us. We are not obligated to ask for any proof. Any delay in submitting proof will not cause a request to be denied if the proof is given to us as soon as reasonably possible.

After receipt of such proof, we may require the covered person to be examined by a licensed physician of our choice, at our expense. If there is a disagreement between the two physicians, we may require the covered person to be examined by another licensed physician of our choice, at our expense. The decision of the third physician will be final.

Effect of Payment of an Accelerated Benefit on Policy Provisions

The covered person's amount of life insurance under the policy will be reduced by the amount of any accelerated benefit that has been previously paid.

The following will be based on the reduced life insurance amount:

1. the amount of life insurance payable to the beneficiary when the covered person dies;
2. the amount of life insurance the covered person can convert under the policy; and
3. the premiums payable for the covered person's life insurance under the policy after an accelerated benefit is paid to you, if such premiums are not waived.

Exclusions

We will not pay an accelerated benefit if:

1. the covered person has made an absolute assignment of his life insurance under the policy and we do not receive written consent by the absolute assignee;
2. all or part of the covered person's life insurance under the group policy is to be paid to his children or former spouse as part of a court approved divorce agreement;
3. the covered person has made an irrevocable beneficiary designation of his life insurance under the policy and we do not receive written consent by the irrevocable beneficiary; or
4. the terminal illness is a result of intentional self-inflicted injury or attempted suicide, committed while sane or insane.

Date Insurance Ends under this Benefit

A covered person's insurance under this benefit will end at the earliest of:

1. the date the accelerated benefit is paid to you on the covered person's behalf;
2. the date the covered person's life insurance ends under the policy; or
3. the policy anniversary on which the covered person is age 70.

Important Notice

The following information is provided to assist you in answering any questions you might have:

Soliciting Agent
The name, address and telephone number of our soliciting agent is available to you, if needed, by calling our Customer Service Department at [(800) 370-5856].

USAble Life

USAble Life
P. O. Box 1650
Little Rock, AR 72203-1650
Toll Free [(800) 370-5856]

If we fail to provide you with reasonable and adequate service, you may contact:

Arkansas Insurance Department

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Phone (501) 371-2640 or
Toll Free 1-800-852-5494

We appreciate the opportunity to serve your insurance needs.

ERISA Information

Plan Sponsorship and Administration

The plan was established by the actions of your employer, which continues to act as Plan Sponsor and Plan Administrator. Your employer, as Plan Administrator, performs the functions of distributing Plan notices and information to employees and other Plan participants, coordinates employees' and eligible dependents' enrollment in the Plan, and transmits Plan premium payments.

ERISA Rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.
4. Neither your employer, nor any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
5. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
6. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, provided that you have first followed the Plan's designated appeals procedure before bringing suit.
7. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees.
8. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
9. If you have any questions about your Plan, you should contact the Plan Administrator.
10. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

USAble Life

[320 W. Capitol] • P.O. Box 1650 • Little Rock, AR 72203-1650
[(501) 375-7200 • (800) 648-0271]

CERTIFICATE OF INSURANCE

Voluntary Group Term Life

Policyholder: SIMMONS FIRST NATIONAL BANK

Class: 002 – ALL FULL TIME ACTIVE EMPLOYEES

State of Residence: ARKANSAS

This is to certify that USAble Life has issued and delivered the Insurance Policy to the Policyholder.

The policy insures the employees and their dependents, if elected, of the policyholder who:

1. eligible for the insurance;
2. become insured; and
3. continue to be insured;

according to the terms of the policy.

The terms of the policy that affect your insurance are contained in the following pages.

This Certificate of Insurance is a part of the policy. This certificate replaces any other that USAble Life may have issued to the policyholder to give to you under the Group Insurance Policy specified herein.

Signed for USAble Life:

James L. Tourse — Secretary

Jason Ram — President

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Schedule of Insurance

Policyholder: SIMMONS FIRST NATIONAL BANK

Group Policy Number: 50001328

Policy Effective Date: September 1, 2011*
*This certificate replaces any certificate issued before the date shown.

Eligible Class: Class 002 - ALL FULL TIME ACTIVE EMPLOYEES

Annual Enrollment Date: July 1 of each year

Full-time Employment: 30 hours weekly

Renewal Date: September 1, 2013

Waiting Period: You will be eligible for coverage on the first of the policy month following completion of the following period of continuous active work:

1. If you are working for the employer on the policy effective date – 0 days
2. If you start working for the employer after the policy effective date – 30 days

Benefits amounts for eligible employees shall be determined in accordance with the following schedule:

Benefit	Benefit Amount
Employee Voluntary Life	The amount elected by you on your enrollment form. Elected in $10,000 increments up to a maximum of $500,000 or 5 times Basic Annual Salary, whichever is less.
Life Insurance – Portability Option	Voluntary Life
Spouse Voluntary Dependent Life	The amount elected by you on your enrollment form. Elected in $10,000 increments up to a maximum of $250,000.
Children Voluntary Dependent Life	6 months and over: $5,000 or $10,000, as elected by you on your enrollment form. Age live birth to 6 months: $1,000
Group Life Accelerated Benefits	75% up to $250,000

If a covered person is eligible for any amount in excess of the guaranteed issue amount shown below, the employee must furnish evidence of insurability, which is subject to our approval.

Benefit	**Guaranteed Issue Amount**
Employee Voluntary Life	
Through age 69	$200,000
Age 70 and over	$0
Spouse Voluntary Dependent Life	$50,000
Through age 69	$0
Age 70 and over	
Children Voluntary Dependent Life	$10,000

Reductions, Terminations, and Special Provisions	
Employee Voluntary Life	Reduces to 65% at age 65 and to 50% at age 70. Terminates at retirement.
Spouse Voluntary Dependent Life	Reduces to 65% at the spouse's age 65 and to 50% at the spouse's age 70. Terminates at retirement.

Definitions

The terms listed, if used, will have these meanings.

Accident or Injury mean accidental bodily injury sustained by the covered person while insured under the policy which is the direct cause of the loss, independent of disease or bodily infirmity or any other cause.

Active Work or Actively at Work mean the expenditure of time and energy for the policyholder or an associated company at your usual place of business on a full-time basis. If you are not working on a day your coverage would otherwise take effect, you will be considered to be at active work on that day only if:

1. when that work day begins, it would be reasonable to expect that you would be physically and mentally able to complete a full-time week of work in your regular occupation; and
2. you are not disabled; and
3. your contract of employment, if applicable, remains active; and
4. you are not on an unapproved, administrative or disciplinary leave; and
5. you return to work at the end of a paid break or vacation period.

Annual Enrollment Period means the 60 days prior to and the 30 days immediately following the Annual Enrollment Date shown in the Schedule of Insurance.

Annual Salary means your annual base rate of pay, excluding any overtime pay, bonuses, or other extra pay. If your pay is from commissions, your annual salary will be based on your average commissions for the prior 12 months.

Associated Company means any company shown in the application which is owned by or affiliated with the policyholder.

Beneficiary means the person or entity you choose to receive your amount of insurance at your death.

Contributory means you pay part of the premium.

Covered Person means an eligible employee or the employee's dependents whose insurance has become and remains effective under all the conditions and provisions of the policy. Covered persons do not include contract, temporary, seasonal, or part-time workers.

Dependent means an eligible person who is:

1. your spouse, if not legally separated from you;
2. any unmarried child less than age 25, who is:
   a. not working on a full-time basis, and
   b. depends upon you for more than 50% of his support; or
3. a handicapped child, as defined in the Continuation of Insurance for a Handicapped Child section, age 25 years or over, who was insured under this policy before reaching age 25.

The term "child" also includes a legally adopted child or child placed for adoption, stepchild, foster child, or any child who lives with you, and depends on you for more than 50% of his support.

Eligible Class means a class of persons eligible for insurance under the policy. This class is based on employment or membership in a group.

Eligible Persons means a person who:

1. is a citizen of the United States of America (U.S.) or Canada, who either:

a. resides in the U.S. or Canada; or
b. is stationed outside the U.S. or Canada for a period of less than 6 months; or

2. is a foreign national residing in the U.S. and meets all of the following requirements:
   a. has a valid permanent residency visa;
   b. participates in U.S. Social Security; and
   c. is covered by Workers' Compensation.

Employee means an eligible person who is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the policyholder or an associated company; or
4. a retiree, if listed as eligible in the policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the above conditions.

Employer means the policyholder.

Evidence of Insurability means a signed health and medical history form provided by us, a medical examination, if requested, and any additional information and attending physicians' statements that we may require.

Family Member means a person who is a parent, spouse, child, sibling, domestic partner, grandparent, grandchild, step-child, step-parent, step-sister, step-brother, father-in-law, or mother-in-law of the covered person; or spouses, as applicable, of any of these.

Full-time means working at least the number of hours indicated in the Schedule of Insurance for Full-time employment.

Gender – The use of the male pronoun also includes the female.

Home Office means the principal office of USAble Life in Little Rock, Arkansas.

Hospital means a facility supervised by one or more physicians and operated under state and local laws. It must have 24-hour nursing service by registered graduate nurses. It may specialize in treating alcoholism, drug addiction, chemical dependency, or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged.

Hospital Confined and Hospital Confinement mean staying in a hospital as a registered inpatient for 24 hours a day.

Material Duty or Material Duties mean the sets of tasks or skills required generally by employers from those engaged in an occupation. We will consider one material duty of your regular occupation to be the ability to work for an employer on a full-time basis as defined in the policy.

Noncontributory means the policyholder pays the premium.

Occupation means a group of jobs:

1. in which a common set of tasks is performed; or
2. which are related in terms of similar objectives and methodologies, and which may be related in terms of materials, products, worker actions, or worker characteristics.

Physician means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. This includes a person whom we are required to recognize as a physician by the laws or regulations of the governing jurisdiction. However, neither you nor a family member will be considered a physician.

Plan means the policy and certificates of insurance provided for covered persons.

Plan Administrator means the employer that sponsors the plan for the benefit of its employees and eligible dependents.

Policy means the group policy issued by us to the policyholder that describes the benefits for which you may be eligible.

Policyholder means the entity to which the policy is issued.

Regular Care means you personally visit a physician as often as is medically required to effectively manage and treat your disabling condition(s), according to generally accepted medical standards; and you are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the sickness or injury causing your disability must be given by a physician whose specialty or experience is appropriate.

Regular Occupation means the occupation in which you were working immediately prior to becoming disabled.

Retiree or Retirement means you begin receiving retirement benefits from either:

1. a retirement plan sponsored by your employer, the policyholder, or an associated company, or
2. a government plan.

Sickness means a disease or illness, including pregnancy.

United States of America means the fifty (50) states of the United States and the District of Columbia. It does not include territories of the United States.

Waiting Period is the number of continuous days of service during which you must be an active, full-time employee in a class eligible for insurance before you become eligible for coverage.

We, Us, and Our mean USAble Life.

You and Your mean an employee of the policyholder or an associated company who has met all the eligibility requirements for coverage, and is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the employer, or associated company covered under the policy; or
4. a retiree, if listed as eligible in the group Policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the conditions listed above.

Eligibility and Effective Date Provisions

Eligible Employee

If you are working on a full-time basis for the employer, you are eligible for insurance after completion of the required waiting period, provided you are in a class of employees who are included.

Employee Eligibility Date

If you are working for your employer in an eligible class, the date you are eligible for coverage is the latest of the following dates:

1. the policy effective date;
2. the day after you complete any waiting period shown in the Schedule of Insurance by continuous service with the employer, the policyholder, or an associated company;
3. the date the policy is changed to include your class; or
4. the date you become a member of a class eligible for insurance.

If you do not apply for voluntary coverage when you are first eligible, you will again be eligible on the first Annual Enrollment Date as shown in the Schedule of Insurance which immediately follows the date noted in items 2, 3, or 4 above.

Effective Date of Employee Insurance

You must use forms approved by us when applying for insurance.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When your Employer pays 100% of the cost of your coverage under the policy, you will be covered at 12:01 a.m. at your employer's address on your eligibility date.
2. When you and your Employer share the cost of your coverage under the policy or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. at your employer's address on the latest of the following dates:
   a. on your eligibility date, if you enroll for insurance within 31 days after the date you first become eligible for coverage; or
   b. on the first day of the policy month following the date we approve your application if you do not apply for insurance within 31 days after your eligibility date; or
   c. for voluntary coverage only, on the Annual Enrollment Date as shown in the Schedule of Insurance if you enroll during the annual enrollment period. If you do not apply for voluntary coverage during the first annual enrollment period following your eligibility date, you will be required to submit satisfactory evidence of insurability.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, your coverage will be effective on the first day of the policy month following the date we approve your application.

Delayed Effective Date

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, it will take effect on the day you return to active work. If your insurance is scheduled to take effect on a non-working day, your active work status will be based on the last working day before the scheduled effective date of your insurance.

Dependent Eligibility

Dependents are eligible for insurance on the latest of the following dates:

1. the date you become eligible for dependent insurance;
2. the date a person becomes a dependent; or

3. the date the policy is amended to include your class as being eligible for dependent insurance.

If you do not apply for voluntary dependent coverage when you are first eligible, you will again be eligible on the first Annual Enrollment Date as shown in the Schedule of Insurance which immediately follows the date noted in items 1, 2, or 3 above.

Your spouse or child will not be eligible for dependent insurance if either is insured under the policy as an employee.

If both you and your spouse are insured as employees, your eligible children may be insured as dependents of only one of you.

Effective Date of Dependent Insurance

You must use forms approved by us when applying for dependent insurance.

Dependents will not be insured until you are insured.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When your Employer pays 100% of the cost of your dependent coverage under the policy, your dependents will be covered at 12:01 a.m. at your employer's address on your dependent's eligibility date.
2. When you and your Employer share the cost of your dependent coverage under the policy or when you pay 100% of the cost yourself, your dependents will be covered at 12:01 a.m. at your employer's address on the latest of the following dates:
   a. on your dependent's eligibility date, if you enroll for dependent coverage within 31 days after the date your dependent first becomes eligible for coverage; or
   b. on the first day of the policy month following the date we approve your application for dependent coverage if you do not apply for dependent coverage within 31 days after your dependent's eligibility date; or
   c. for voluntary coverage only, on the Annual Enrollment Date as shown in the Schedule of Insurance if you enroll during the annual enrollment period. If you do not apply for voluntary dependent coverage during the first annual enrollment period following your dependent's eligibility date, you will be required to submit satisfactory evidence of insurability.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, your dependent's coverage will be effective on the first day of the policy month following the date we approve your application for dependent coverage.

You must furnish satisfactory evidence of the dependent's insurability at your own expense if you have previously terminated dependent coverage while in an eligible class.

Delayed Effective Date

Coverage for a dependent, other than a newborn child, who is confined in a hospital on the day dependent insurance or an increase in insurance is scheduled to take effect will not become effective until the 10th day following final discharge from the hospital.

Changes in Coverage Provisions

When Coverage Amounts Change (Redetermination Date)

The policy redetermines your amount of insurance on the first of the policy month after a change occurs. If benefits are based on your salary, the policyholder must report updates to all covered person's earnings as they occur. Changes to a covered person's earnings are subject to any proof of insurability requirements of the policy. As of the policy's redetermination date, we use a covered person's salary or earnings on record with us to: (a) set rates; (b) set benefit amounts and limits; and (c) calculate premium payable under the policy.

Delayed Effective Date of Change

You must be actively at work on a full-time basis on the redetermination date. If you are not, your coverage amount will not change until the date you return to active work on a full-time basis. Changes in salary or earnings will not apply to a recurring disability.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

Changes to the Policy

Any increase or decrease in coverage because of a change in the plan of insurance will become effective on the date of the change. The Delayed Effective Date provision will apply to an increase.

Termination Provisions

Termination of Employee Insurance

Your insurance will terminate at 12:00 midnight on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date the policy terminates, or the date a specified benefit terminates;
3. the date you cease to be a member of a class eligible for insurance;
4. the date you cease to be actively at work;
5. if your coverage is continued under the Waiver of Premium provision, the date specified under "Termination of the Extended Insurance Benefit."

Continuation of Insurance

If you are unable to perform active work for a reason shown below, the policyholder may continue your insurance, except for any Accidental Death and Dismemberment coverage, on a premium-paying basis provided you remain in other respects a member of an eligible class. The continuance cannot be more than the maximum continuance shown below. The employer must act so as not to discriminate unfairly among employees in similar situations.

The maximum continuance for insurance is the longest applicable period described below:

1. six months following the date active work stopped due to lay-off or approved leave of absence, or
2. twelve months following the date active work stopped due to your total disability.

Total Disability for Continuation of Insurance means that you are under the regular care of a physician, and prevented by injury or sickness from performing all of the material duties of your regular occupation.

Termination of Dependent Insurance

Insurance on a dependent will terminate at 12:00 midnight on the earliest of the following dates:

1. the date he ceases to be a dependent as defined in the Definitions section;
2. the date you cease to be an employee or a member of a class eligible for dependent insurance;
3. the last day of the period for which a required dependent premium payment is made, if the next payment is not made; or
4. the date the policy terminates, or a specific benefit terminates.

Continuation of Insurance for a Handicapped Dependent Child

If an unmarried dependent child is not capable of self-sustaining employment due to mental or physical handicap, his insurance will not terminate at age 25. The insurance will continue as long as the child remains handicapped, unless coverage terminates as described in the Termination of Dependent Insurance section, if you give us proof that the child is:

1. incapable of self-sustaining employment; and
2. chiefly dependent on you for support and maintenance.

To keep this coverage in force, we may require proof at our expense of the child's incapacity and dependence. We may require proof from time to time, but not more than once a year after the two years that follow the date the child reaches age 25.

Claim Provisions

Notice of Loss

Written notice of claim must be given to us at our Home Office within 30 days after a loss occurs or begins, or as soon after the loss as is reasonably possible to do so, but not later than one (1) year from the time notice is required. The notice should identify the covered person and the nature of the loss.

Within 15 days after the date of your notice, we will send you claim forms. The forms must be completed and sent to our Home Office. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.

Proof of Loss

For any loss for which the policy provides periodic payment contingent upon continuing loss, written proof of loss must be given to us within 90 days after the termination of the period for which we are liable. For any other loss covered by the policy, written proof of loss must be given to us within 90 days after the date of such loss. Failure to furnish proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time. Such proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof was otherwise required.

Physical Examination and Autopsy

We have the right to have a physician of our choice examine the covered person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.

Payment of Claims

All benefits payable under this policy will be payable immediately upon receipt of due written proof of such loss.

If included, Dependent Life benefits will be paid to you. Employee Life insurance benefits will be paid to the person(s) named by you to receive them.

If you failed to name a beneficiary or if no named beneficiary is living at your death, refer to the “Beneficiary” provision below. At our option, up to the maximum allowable by the state laws of the covered person’s state of residence may be paid to any person who incurred funeral or other expenses related to the last illness or death of the covered person.

Beneficiary

Your beneficiary will be the person(s) you name in writing to receive any amount of insurance payable due to your death. The beneficiary's name is on record in our Home Office, or in the policyholder's office if the group is self-administered. You are the beneficiary of the Dependent Life Insurance if you are living. If you and your dependent die in the same accident, the dependent benefit will be paid to your estate.

You may name or change a beneficiary by giving us written notice at our Home Office (or by giving the policyholder written notice if the group is self-administered) on a form acceptable to us. When we receive the notice, it will be effective on the date made, subject to any payment we may have made before we receive it.

If there is no named beneficiary living at your death, we may pay, at our discretion, any amount due to one of the following classes of survivors: (1) your spouse; (2) your surviving children in equal shares; (3) your mother and/or father; (4) your brother and/or sister; or (5) your estate.

Assignment

You may transfer your rights to name or change the beneficiary to someone else by assignment. An assignment will affect us only if it is in writing on a form acceptable to us, and is received at our Home Office. When we record it, the assignment will take effect as of the date you made it. The assignment will be subject to any action we may have taken before we record it. We take no responsibility for the validity of any assignment.

Claims of Creditors**:** To the extent allowed by law, proceeds will not be subject to any claims of a beneficiary's creditors.

Authority

The policyholder delegates to us and agrees that we have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the policy.

We decide: (a) if a covered person is eligible for this insurance; (b) if a covered person meets the requirements for benefits to be paid; and (c) what benefits are to be paid by the policy. We also interpret how the policy is to be administered. What we pay and the terms for payment are explained in this certificate.

Limit on Legal Action

No action at law or in equity may be brought against the policy until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations has expired, but, in any case, not after three (3) years from the date of loss.

Review Procedure

You must request, in writing, a review of a denial of your claim within 180 days after you receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit written comments, documents, records and other information relating to your claim for benefits.

We will review your claim after receiving your request and send you a notice of our decision within 45 days after we receive your request, or within 90 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant provisions of the policy. We will also advise you of your further appeal rights, if any.

Subrogation and Right of Reimbursement

The plan assumes and is subrogated to your legal rights to recover any payments the plan makes for benefits, when a covered sickness or injury resulted from the action or fault of a third party. The plan's subrogation rights include the right to recover the amount of benefits paid to you.

The plan has the right to recover any and all amounts equal to the plan's payments from:

1. the insurance of the injured party;
2. the person, company (or combination thereof) that caused the sickness or injury, or any insurance company; or
3. any other source, including disability benefit coverage.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The plan's recovery will not be reduced by your negligence, nor by attorney fees and costs you incur.

Priority Right of Reimbursement

Separate and apart from the plan's right of subrogation, the plan shall have first lien and right to reimbursement. This priority right of reimbursement supersedes your right to be made whole from any recovery, whether full or partial. You agree to reimburse the plan 100% first for any and all benefits provided through the plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

1. any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from your own insurance and/or from the third party (or their insurance);
2. any auto or recreational vehicle insurance coverage or benefits including, but not limited to disability benefit coverage; and
3. business and homeowner disability insurance coverage or payments.

The plan may notify those parties of its lien and right to reimbursement without notice to or consent from any covered person.

This priority right of reimbursement will not be reduced by attorney fees and costs you incur.

The plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available disability insurance coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

Notice and Cooperation

You are required to notify us promptly if you are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable us to protect the plan's rights under this section. You are also required to cooperate with us and to execute any documents that we, acting on behalf of the policyholder, deems necessary to protect the plan's rights under this section.

You shall not do anything to hinder, delay, impede or jeopardize the plan's subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the plan to withhold any and all benefits due you under the plan. This is in addition to any and all other rights that the plan has pursuant to the provisions of the plan's subrogation rights and/or priority right of reimbursement.

If the plan has to file suit, or otherwise litigate to enforce its subrogation rights and/or priority right of reimbursement, you are responsible for paying any and all costs, including attorneys' fees, the plan incurs in addition to the amounts recovered through the subrogation rights and/or priority right of reimbursement.

Legal Action and Costs

If a covered person settles any claim or action against any third party, that covered person shall be deemed to have been made whole by the settlement and the plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. The covered person shall hold any such proceeds of settlement or judgment in trust for the benefit of the plan. The plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the covered person in such circumstances.

Additionally, the plan has the right to sue on the covered person's behalf, against any person or entity considered responsible for any condition resulting in benefits paid or to be paid by the plan.

Settlement or Other Compromise

The covered person must notify the plan prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the plan's rights so that the plan may be present and protect its subrogation rights and/or priority right of reimbursement.

The plan's subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against the covered person.

The right of subrogation and the right of reimbursement are based on the plan language in effect at the time of judgment, payment, or settlement.

The plan, or its representative, may enforce the subrogation and priority right of reimbursement.

Alternate Dispute Resolution Procedures

This dispute resolution procedure ("procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all disputes with us. Such disputes include any matters that cause you to be dissatisfied with any aspect of your relationship with us, including any claim, controversy, or potential cause of action you may have against us. Please contact the Dispute Resolution office at (800) 648-0271 if you have any questions about this section of the certificate or to begin the dispute resolution process.

The following terms are applicable to all disputes:

1. This procedure is the exclusive method of resolving any disputes.
2. The procedure can only resolve disputes that are subject to our control.
3. This procedure will be governed by the Employee Retirement Income Security Act of 1974 ("ERISA"); Rules and Regulations for Administration and Enforcement; Claims Procedure (the "Claims Regulation"). That includes the definition of an adverse benefit determination, which is defined as any denial, reduction, termination or failure to provide or make payment for what you believe should be a covered benefit.
4. You may request a form from our Dispute Resolution office to authorize another person to act on your behalf concerning a dispute.
5. We may elect to skip one or more of the steps of this procedure if it is determined that step will not help to resolve the dispute.
6. Any dispute will be resolved in accordance with the terms of this certificate, applicable state or Federal laws and regulations.
7. You must begin the dispute process within 180 days from the date you receive notice of an adverse benefit determination. If you do not initiate the dispute process within that 180 day period, you give up the right to take any action based on that Dispute.

Description of the Procedure

Inquiry

You should contact our Dispute Resolution office to discuss and attempt to resolve any issues regarding a dispute. We hope that this informal process will resolve your questions or concerns.

Appeals

If you are not satisfied with the response to your inquiry, you may submit a written request (an "appeal") to the Office of the Appeals Coordinator, USAble Life, P.O. Box 1650, Little Rock, AR 72203-1650, asking that we reconsider an adverse benefit determination. Please contact the Dispute Resolution office if you have any questions about how to submit an appeal to us. You are not required to use a specific form, but you may request that the Dispute Resolution office send you a blank appeal form to ensure that you provide the information that will be needed to review your appeal.

We will assign a coordinator to review your appeal. The appeal coordinator is an individual with appropriate expertise who is neither the individual who made the adverse benefit determination, nor a subordinate of that individual.

The appeal coordinator may request that you submit additional information concerning your grievance. The appeal coordinator will also consider information submitted by others, including information requested from other USAble Life representatives. The appeal coordinator will have full discretionary authority to make eligibility, benefit or claim determinations and construe the terms of the policy. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the policy is not governed by ERISA.

We will make a decision within 60 days after receiving your appeal concerning a claim determination.

The appeal coordinator will send you a written decision concerning your appeal. The appeal coordinator's decision will include: a statement of the coordinator's understanding of your appeal; a statement explaining the basis of the decision; and a list of the documents or information upon which that decision was based. We will send you a copy of the listed documents, without charge, if you make a written request for such documents.

Post Appeal Procedure

If you are still not satisfied after completing the appeal procedure, you have the right to bring a civil action against us to obtain the remedies available pursuant to Sec. 502(a) of ERISA (an "ERISA Action") after completing the mandatory appeal process. Those ERISA remedies will apply to this policy even if your plan is not otherwise governed by ERISA. If you agree to arbitrate a dispute, we agree to suspend (or toll) any time periods affecting your right to bring an ERISA Action against us related to that dispute, until the arbitration has been completed.

You may request that the dispute be submitted for resolution by arbitration. That arbitration request must be submitted, in writing, to USAble Life's General Counsel within sixty (60) days after you receive the appeal coordinator's decision.

The dispute will be submitted to arbitration in accordance with the rules of the American Arbitration Association, unless we both agree to use an alternative dispute resolution administrator or procedure. The arbitration will be conducted before a single arbitrator.

We will pay the filing fee charged by the administrator and the arbitrator. You will be solely responsible for any other costs that you incur to participate in the arbitration process, including your attorney's fees. The filing fee and arbitrator's fees may be reallocated as part of an arbitration award, in whole or in part, at the discretion of the arbitrator.

The arbitration will be conducted in a location where it is reasonably convenient for you to participate. If we cannot agree concerning a convenient location, the administrator or arbitrator, if appointed, shall have the discretion to decide where the arbitration will be conducted.

The arbitrator: (a) shall consider the dispute individually and shall not certify or consider multiple disputes as part of a class action; (b) shall be required to issue a reasoned written decision explaining the basis of his or her decision and the manner of calculating any award; (c) shall limit his or her decision to deciding if our adverse benefit decision was arbitrary or capricious based on ERISA standards; (d) may not award punitive, extra-contractual, treble or exemplary damages unless permitted to do so by applicable statutes or regulations; (e) may not vary or disregard the terms of the policy; and (f) shall be bound by controlling law; when issuing a decision concerning the dispute.

The arbitrator shall limit discovery to the extent possible consistent with the objective of completing the arbitration in a fair, prompt, and cost effective manner. Emergency relief such as injunctive relief may be awarded by the arbitrator.

Contact Information

General Counsel
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: [(800) 648-0271]
Email: AppealCoordinator@usablelife.com

Office of the Dispute Resolution Coordinator
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: [(800) 648-0271]
Email: AppealCoordinator@usablelife.com

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General Provisions

Entire Contract

This certificate is furnished in accordance with and subject to the terms of the policy. The entire contract consists of the policy, which includes the application, any amendments and addenda; this certificate; your enrollment form, if required; and any riders or endorsements. No change in the policy will be effective until approved by one of our officers. This approval can only be in writing and must be noted on or attached to the policy. No agent has authority to change the policy or certificate or to waive any of their provisions.

Any statement made by you or the policyholder is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about you or the policyholder's plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

Incontestability

Unless the premiums have not been paid, the validity of the policy cannot be contested after it has been in force for two years.

Any statement made by the policyholder or a covered person will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the covered person or the beneficiary.

No statement, except fraudulent misstatement, made by a covered person about insurability will be used to deny a claim for a loss incurred or disability starting after coverage has been in effect for two years.

No claim for loss starting two or more years after the covered person's effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Agency

Neither the policyholder, any employer, any associated company, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

Unpaid Premium

We may deduct any unpaid premium then due from the payment of a claim under this certificate.

Refund of Premium

On the death of the covered person, proceeds payable hereunder shall include the amount of unearned premium paid beyond the end of the policy month in which death occurred. Payment shall be made in one lump sum no later than 30 days after proof of the covered person's death has been furnished to us.

Conformity with State Statutes

If the provisions of this certificate do not conform with the laws of the state in which you reside on the certificate effective date, they are hereby amended to conform with the minimum requirements of the statutes of that state.

Policy Management

Efficient management of the policy requires the joint efforts of the policyholder, USAble Life, and each covered person. Each party has certain duties to bring about the effective administration of the policy.

Duties of the Policyholder: The policyholder's primary duties under the policy are listed below.

1. Give us prompt, written notice of any change in business of the policyholder and employer. This includes, but is not limited to: (a) the type of business; (b) addition or deletion of an associated company; or (c) financial status due to bankruptcy; merger; acquisition; or dissolution.
2. Give us pertinent records for all covered persons. This includes, but is not limited to: (a) hire dates; (b) eligibility dates; (c) salaries; (d) occupations; and (e) birth dates. Give us updates of such records as needed.
3. Give us prompt notice of a covered person's disability. This notice should be given as soon as possible after the date of injury or start of sickness. The most effective time for such notice is when the covered person has not been able to perform active work for 30 days.
4. Give us occupational data for all disabled covered persons. This includes, but is not limited to: (a) job descriptions and analyses; and (b) environmental factors.

Duties of Covered Persons and Beneficiaries: Your and your beneficiary's primary duties under the policy are listed below:

1. Give notice and proof of loss as soon as possible after the date of your injury or sickness, or the date of your death, or the death of a covered dependent, if applicable.
2. Give a complete account of the details of your injury or sickness or the death on a form approved by us.
3. Provide any other official documents to review the loss such as a certified death certificate, investigating officer's report, or medical records.
4. Allow release of medical and income data needed to adjudicate your claim.
5. Provide evidence of the regular care of a physician, if necessary.
6. Promptly report to us any changes in your status such as your address or telephone number, or if you return to work or are no longer disabled.
7. If benefits are overpaid, reimburse such overpayment within 60 days of the date benefits were overpaid.
8. Provide proof of your earnings for the period prior to a loss.

Fraud

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the policy and recovery of any amounts we have paid.

Employee Term Life Insurance

Death Benefit

We will pay your beneficiary the amount of insurance in force on the date of death, as shown in the Schedule of Insurance, when we receive all required proof of loss, including written proof of your death acceptable to us and a completed claim form.

Suicide

This provision applies to Voluntary Life only. If you, whether sane or insane, die by suicide within one year(s) of your original effective date of insurance, the death benefit will be limited to the amount of premiums paid for your insurance.

After having been insured for one year(s), if you, whether sane or insane, die by suicide within one year(s) of the effective date of an increase in coverage, the death benefit will be limited to the amount of insurance in effect prior to the increase in coverage, plus the amount of premiums paid for the increase in coverage.

With respect to employees insured on the effective date of the policy:

1. if the policy replaces another group life policy, the one year(s) limitation on death by suicide shall be reduced by the number of months you were continuously insured by the prior policy; and
2. the benefit payable shall be the lesser of the amount otherwise payable under this policy or the amount provided by the prior policy.

Conversion Privilege for Life Insurance

Conversion upon Termination of Employment or Eligibility

For Employees

You may convert all or part of your life insurance to an individual policy of life insurance, other than Term,

1. if all or part of it stops for any reason; unless
2. it stops because you did not pay any required premiums.

The amount you may apply for may not be more than:

1. the life amount then in force; or
2. that part of the life amount which has stopped, whichever is less.

Accidental death and dismemberment, disability or any other supplemental coverage for which you are eligible under this policy may not be converted.

For Dependents

Your covered dependent spouse or child may convert all or part of his life insurance to an individual life policy, other than Term, if the insurance on his life ends because:

1. you stopped working full-time for your employer; or
2. you ceased to be a member of a class eligible for insurance; or
3. the dependent ceased to be an eligible family member; or
4. of your death.

Conversion upon Termination or Amendment of Group Policy

Any covered person may convert a limited amount of life insurance if he has been continuously insured under the policy for at least five (5) years and his insurance ends due to termination or amendment of the policy.

The amount you may convert in this case is the smaller of the following:

1. the amount of life insurance which terminates, less the amount you became eligible for under any group policy within 31 days after this insurance terminated; or
2. $10,000.

Conversion Coverage

Any covered person may convert his life insurance to any policy we are issuing for the purpose of conversions other than Term. The conversion policy will not have disability or other supplementary benefits. No evidence of insurability will be required. The premium will be based on the amount and the form of the conversion policy, and on the covered person's class of risk and age on the date the conversion takes effect.

A conversion policy is in lieu of all other benefits under this policy. If you qualify for the Extended Insurance Benefit, any conversion policy issued will be canceled. Premiums paid for the converted policy will be returned.

The conversion policy will take effect on the 32nd day after the insurance terminates.

Notice and Application Required

Written application and the first premium payment for the conversion policy must be received in our Home Office within 31 days after the covered person's insurance terminates. If you are not given notice of the right to convert by the 16th day of the 31 day conversion period, you will have an additional period in which to apply for conversion. The additional period will end 15

days after you are given notice, but not more than 61 days after the date the insurance under the policy ended.

Nothing in the policy will continue coverage for more than 31 days following the date coverage ends under the policy. Written notice, contained in this certificate of insurance and given to you at any time, or mailed by the policyholder to your last known address will be considered sufficient written notice to you. It is the responsibility of the policyholder to give such notice to you.

Conversion Period Death Benefit

If the covered person dies within the 31 days allowed for making application to convert, we will pay the amount he was entitled to convert. We will do this whether or not application was made.

Life Insurance – Waiver of Premium

This section applies to the Voluntary Life Insurance Benefit only.

Extended Insurance Benefit (Waiver of Premium)

We will continue the term life insurance in force on you and your covered dependents without premium payment if you become totally disabled provided:

1. you are insured under this plan and are actively at work on or after the effective date of the plan; and
2. your total disability begins before age 70; and
3. you provide us with proof of total disability as required; and
4. you are still totally disabled when you submit the proof of disability.

Dependent premiums will only be waived if the employee is also covered and his premiums are waived.

Amount of Life Insurance

The amount of life insurance continued will be the amount in force on the date you became totally disabled. This amount will be reduced or terminated based on the Schedule of Insurance in effect on the date of total disability. This amount will not be increased while you remain totally disabled.

Definition of Total Disability

For the purposes of waiver of premium, "total disability" or "totally disabled" means that you are under the regular care of a physician, and prevented by injury or physical or mental sickness from performing the material duties of any gainful occupation.

Gainful Occupation means any employment that exists in the national economy that you may be expected to follow based on your education, training, experience, age, and physical and mental capacity, and from which you are expected to earn at least 80% of your pre-disability earnings within 12 months of your return to active work.

Proof of Total Disability

Upon receipt of Notice of Loss, we will provide forms which you must use when giving us proof of total disability. (See "Notice of Loss" under the Claim Provisions.) You must give us proof no later than 12 months after the date you became totally disabled. We may at any time require proof that total disability continues. You must give us proof of continuing disability within 60 days after our request. After you have been totally disabled for more than two years from the date of total disability, we will not request proof more than once a year. We may require that you be examined at our expense by a physician of our choice.

Death While Totally Disabled

If you die while your life insurance is being continued under this provision, we will pay the amount of insurance if we receive proof:

1. of your death; and
2. that total disability was continuous from the date it began to the date of death.

Termination of the Extended Insurance Benefit

You will no longer be eligible for the Extended Insurance Benefit and your life insurance will terminate on the earliest of the following dates:

1. the date you cease to be totally disabled. But, if you are still eligible for life insurance when you return to active work, your life insurance may be continued in force if premium payments are resumed. If this is done, any increased amount of life insurance you may then be eligible for will take effect as described in the Effective Date of Insurance provision; or
2. the last day of the 60 day period following our request for proof of total disability, if you do not give us proof or you refuse to take a medical exam; or
3. the date you attain age 70.

If your life insurance terminates while you are covered under this provision, you will be eligible to convert that coverage as of the termination date. You may convert no more than the amount of term life insurance that was in force on you on that date. (See "Conversion Privilege for Life Insurance" provision.)

Termination of the Extended Insurance Benefit for the Covered Dependent

Your covered dependent will no longer be eligible for the Extended Insurance Benefit and the dependent's life insurance will terminate on the earliest of the following dates:

1. the date the dependent ceases to be a dependent as defined in the Definition section; or
2. the date you cease to be eligible for coverage under the Extended Insurance Benefit (Waiver of Premium) provision. But, if the dependent is still eligible for dependent life insurance when you return to active work, the dependent life insurance may be continued in force if premium payments are resumed. If this is done, any increased amount of dependent life insurance the dependent may then be eligible for will take effect as described in the Effective Date of Dependent Insurance provision; or
3. 12 months from the date your total disability began.

Your covered dependent whose insurance terminates while covered under this provision will be eligible to convert that coverage as of the termination date. He may convert no more than the amount of dependent life insurance that was in force on that date. (See "Conversion Privilege for Life Insurance" provision.)

Life Insurance – Portability

This section applies to the Voluntary Life Insurance Benefit only.

Portability Benefit

You may continue your and your spouse's voluntary term life insurance if your employment terminates and you meet the following requirements on the date your employment terminates:

1. you are not disabled; and
2. you either:
   a. are not retired and are under age 70; or
   b. you are retired and are under age 65.

Coverage will be continued under the policy for employees who elect continuation of coverage under this portability provision. Portability is not available upon policy cancellation.

Your spouse's term life insurance may not be continued if your term life insurance is not continued. Dependent children are not eligible for the Portability provision; however, the dependent children's coverage may be converted under the "Conversion Privilege" provisions of the policy.

"Retired" means you are a former employee who has begun receiving one of the following:

1. retirement pension benefits under any plan of a federal, state, county or municipal retirement system, if such pension benefits include any credit for employment with the policyholder;
2. retirement pension benefits under any plan which the policyholder sponsors or makes or has made contributions; or
3. retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act.

Application and Premium Payment

You must apply for portability in writing to USAble Life within 31 days after the date your employment ends.

You must pay the required premium quarterly, semi-annually, or annually directly to USAble Life. The premium rate will be determined by us. The first premium payment must be made no later than 31 days after the date the insurance would otherwise terminate under the policy.

Amount of Insurance

The amount of insurance that you and your spouse may continue is the amount in effect on the date your employment terminates. The reduction and termination provisions stated in the Change Rider – Portability will apply to insurance continued under this provision.

When Portability Ends

Your continued coverage under this provision will end automatically on the earliest of the following:

1. the date the last period ends for which you made a premium payment;
2. the premium due date after the covered person has continued coverage under this provision for 3 year(s);
3. the premium due date following your attainment of age 70;
4. if your coverage continued due to your retirement prior to age 65, on the premium due date following your attainment of age 65;
5. the date you become a full-time member of the armed forces of any country; or

6. spouse coverage will end on the premium due date following the date the spouse ceases to be a dependent as defined in the policy, or
7. spouse coverage will end on the premium due date following the spouse's attainment of age 65.

When your insurance under the portability provision ends, you and your spouse will be eligible to convert your insurance to an individual policy under the "Conversion Privilege" provisions.

Coverage continued under the portability provision is in lieu of all other benefits under the policy, including conversion. If you return to work with the employer and again become eligible for Term Life coverage under the policy, continued coverage under the portability provision will cancel on the date coverage is resumed under the policy.

Other Policy Provisions

The Life Insurance – Waiver of Premium and the Group Life Accelerated Benefit provisions will not apply to insurance continued under the Portability provision.

With respect to any notice you are required to provide to the employer under other provisions of the policy, you must provide such notice to USAble Life while the insurance is continued under the Portability provision.

Dependent Term Life Insurance

Death Benefit

We will pay the amount of insurance in force on the date of death, as shown in the Schedule of Insurance, when we receive all required proof of loss, including written proof of your covered dependent's death acceptable to us and a completed claim form.

Suicide

If a covered dependent, whether sane or insane, dies by suicide within one year(s) of his original effective date of insurance, the death benefit will be limited to the amount of premiums paid for this insurance.

After having been insured for one year(s), if a covered dependent, whether sane or insane, dies by suicide within one year(s) of the effective date of an increase in coverage, the death benefit will be limited to the amount of insurance in effect prior to the increase in coverage, plus the amount of premiums paid for the increase in coverage.

With respect to dependents insured on the effective date of the policy:

1. if the policy replaces another group life policy providing similar dependent life insurance, the one year(s) limitation on death by suicide shall be reduced by the number of months you were continuously insured for dependent life by the prior policy; and
2. the benefit payable shall be the lesser of the amount otherwise payable under this policy or the amount provided by the prior policy.

Group Life Accelerated Benefit

This section applies to the Voluntary Life Insurance Benefit only.

Notice of Possible Tax Consequences

Please be advised that receipt of the accelerated benefits may be taxable. Any person who receives accelerated benefits should consult his personal tax advisor.

The receipt of accelerated benefit payments may adversely affect the covered person's eligibility for Medicaid or other government benefits or entitlements.

Definitions

"Terminal Illness" means a medical condition:

1. which is expected to result in the covered person's death within 12 months; and
2. from which the covered person is not expected to recover.

Eligibility

All covered employees and covered dependents under age 70 who are insured for a minimum of $10,000 of life insurance under the policy are eligible.

A covered employee or dependent is eligible for the accelerated benefit only if he becomes and remains insured for life insurance under the policy.

Accelerated Benefit

The accelerated benefit is an advance payment to the covered person who:

1. is terminally ill; and
2. elects to receive part of his life insurance benefit payable under the group policy, subject to the maximum benefit amounts stated on the Schedule of Insurance.

We will pay an accelerated benefit to you when we receive the following:

1. a written request for payment of the accelerated benefit; and
2. proof that the covered person is terminally ill and his illness is expected to result in his death within 12 months.

The accelerated benefit will be paid only once for each eligible covered person, and in one lump sum to you before death occurs.

Cost of Providing the Accelerated Benefit

There is no cost associated with providing the accelerated benefit.

Amount of Accelerated Benefit

The maximum accelerated benefit will be the lesser of:

1. 75% of the covered person's life insurance amount; or
2. $250,000.

If the covered person's life insurance amount is scheduled for a reduction within 12 months after the date you request the payment of the accelerated benefit, the maximum accelerated benefit will be based on the reduced amount.

Irrevocable Beneficiary

For the purpose of the Accelerated Benefit provision, an irrevocable beneficiary is a named beneficiary whose rights to the employee's life insurance proceeds are vested and whose rights cannot be cancelled by the employee unless the irrevocable beneficiary consents.

Conditions and Requirements for Payment of the Accelerated Benefit

You must request payment of an accelerated benefit in writing.

Proof that the covered person is terminally ill must be provided to us. The proof must be certified by a licensed physician and in a form that is satisfactory to us. We are not obligated to ask for any proof. Any delay in submitting proof will not cause a request to be denied if the proof is given to us as soon as reasonably possible.

After receipt of such proof, we may require the covered person to be examined by a licensed physician of our choice, at our expense. If there is a disagreement between the two physicians, we may require the covered person to be examined by another licensed physician of our choice, at our expense. The decision of the third physician will be final.

Effect of Payment of an Accelerated Benefit on Policy Provisions

The covered person's amount of life insurance under the policy will be reduced by the amount of any accelerated benefit that has been previously paid.

The following will be based on the reduced life insurance amount:

1. the amount of life insurance payable to the beneficiary when the covered person dies;
2. the amount of life insurance the covered person can convert under the policy; and
3. the premiums payable for the covered person's life insurance under the policy after an accelerated benefit is paid to you, if such premiums are not waived.

Exclusions

We will not pay an accelerated benefit if:

1. the covered person has made an absolute assignment of his life insurance under the policy and we do not receive written consent by the absolute assignee;
2. all or part of the covered person's life insurance under the group policy is to be paid to his children or former spouse as part of a court approved divorce agreement;
3. the covered person has made an irrevocable beneficiary designation of his life insurance under the policy and we do not receive written consent by the irrevocable beneficiary; or
4. the terminal illness is a result of intentional self-inflicted injury or attempted suicide, committed while sane or insane.

Date Insurance Ends under this Benefit

A covered person's insurance under this benefit will end at the earliest of:

1. the date the accelerated benefit is paid to you on the covered person's behalf;
2. the date the covered person's life insurance ends under the policy; or
3. the policy anniversary on which the covered person is age 70.

Important Notice

The following information is provided to assist you in answering any questions you might have:

Soliciting Agent
The name, address and telephone number of our soliciting agent is available to you, if needed, by calling our Customer Service Department at [(800) 370-5856].

USAble Life

USAble Life
P. O. Box 1650
Little Rock, AR 72203-1650
Toll Free [(800) 370-5856]

If we fail to provide you with reasonable and adequate service, you may contact:

Arkansas Insurance Department

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Phone (501) 371-2640 or
Toll Free 1-800-852-5494

We appreciate the opportunity to serve your insurance needs.

ERISA Information

Plan Sponsorship and Administration

The plan was established by the actions of your employer, which continues to act as Plan Sponsor and Plan Administrator. Your employer, as Plan Administrator, performs the functions of distributing Plan notices and information to employees and other Plan participants, coordinates employees' and eligible dependents' enrollment in the Plan, and transmits Plan premium payments.

ERISA Rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.
4. Neither your employer, nor any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
5. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
6. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, provided that you have first followed the Plan's designated appeals procedure before bringing suit.
7. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees.
8. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
9. If you have any questions about your Plan, you should contact the Plan Administrator.
10. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

USAble Life

[320 W. Capitol] • P.O. Box 1650 • Little Rock, AR 72203-1650
[(501) 375-7200 • (800) 648-0271]

CERTIFICATE OF INSURANCE

Voluntary Group Term Life

Policyholder: SIMMONS FIRST NATIONAL BANK

Class: 003 – BOARD OF DIRECTORS MEMBERS

State of Residence: ARKANSAS

This is to certify that USAble Life has issued and delivered the Insurance Policy to the Policyholder.

The policy insures the employees and their dependents, if elected, of the policyholder who:

1. eligible for the insurance;
2. become insured; and
3. continue to be insured;

according to the terms of the policy.

The terms of the policy that affect your insurance are contained in the following pages.

This Certificate of Insurance is a part of the policy. This certificate replaces any other that USAble Life may have issued to the policyholder to give to you under the Group Insurance Policy specified herein.

Signed for USAble Life:

James L. Tourse — Secretary

Jason Kim — President

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Schedule of Insurance

Policyholder: SIMMONS FIRST NATIONAL BANK

Group Policy Number: 50001328

Policy Effective Date: September 1, 2011*
*This certificate replaces any certificate issued before the date shown.

Eligible Class: Class 003 – BOARD OF DIRECTORS MEMBERS

Annual Enrollment Date: July 1 of each year

Full-time Employment: 30 hours weekly

Renewal Date: September 1, 2013

Waiting Period: You will be eligible for coverage on the first of the policy month following completion of the following period of continuous active work:

1. If you are working for the employer on the policy effective date – 0 days
2. If you start working for the employer after the policy effective date – 30 days

Benefits amounts for eligible employees shall be determined in accordance with the following schedule:

Benefit	Benefit Amount
Employee Voluntary Life	The amount elected by you on your enrollment form. Elected in $10,000 increments up to a maximum of $500,000 or 5 times Basic Annual Salary, whichever is less.
Life Insurance – Portability Option	Voluntary Life
Spouse Voluntary Dependent Life	The amount elected by you on your enrollment form. Elected in $10,000 increments up to a maximum of $250,000.
Children Voluntary Dependent Life	6 months and over: $5,000 or $10,000, as elected by you on your enrollment form. Age live birth to 6 months: $1,000
Group Life Accelerated Benefits	75% up to $250,000

If a covered person is eligible for any amount in excess of the guaranteed issue amount shown below, the employee must furnish evidence of insurability, which is subject to our approval.

Benefit	**Guaranteed Issue Amount**
Employee Voluntary Life	
Through age 69	$200,000
Age 70 and over	$0
Spouse Voluntary Dependent Life	$50,000
Through age 69	$0
Age 70 and over	
Children Voluntary Dependent Life	$10,000

Reductions, Terminations, and Special Provisions	
Employee Voluntary Life	Reduces to 65% at age 65 and to 50% at age 70. Terminates at retirement.
Spouse Voluntary Dependent Life	Reduces to 65% at the spouse's age 65 and to 50% at the spouse's age 70. Terminates at retirement.

Definitions

The terms listed, if used, will have these meanings.

Accident or Injury mean accidental bodily injury sustained by the covered person while insured under the policy which is the direct cause of the loss, independent of disease or bodily infirmity or any other cause.

Active Work or Actively at Work mean the expenditure of time and energy for the policyholder or an associated company at your usual place of business on a full-time basis. If you are not working on a day your coverage would otherwise take effect, you will be considered to be at active work on that day only if:

1. when that work day begins, it would be reasonable to expect that you would be physically and mentally able to complete a full-time week of work in your regular occupation; and
2. you are not disabled; and
3. your contract of employment, if applicable, remains active; and
4. you are not on an unapproved, administrative or disciplinary leave; and
5. you return to work at the end of a paid break or vacation period.

Annual Enrollment Period means the 60 days prior to and the 30 days immediately following the Annual Enrollment Date shown in the Schedule of Insurance.

Annual Salary means your annual base rate of pay, excluding any overtime pay, bonuses, or other extra pay. If your pay is from commissions, your annual salary will be based on your average commissions for the prior 12 months.

Associated Company means any company shown in the application which is owned by or affiliated with the policyholder.

Beneficiary means the person or entity you choose to receive your amount of insurance at your death.

Contributory means you pay part of the premium.

Covered Person means an eligible employee or the employee's dependents whose insurance has become and remains effective under all the conditions and provisions of the policy. Covered persons do not include contract, temporary, seasonal, or part-time workers.

Dependent means an eligible person who is:

1. your spouse, if not legally separated from you;
2. any unmarried child less than age 25, who is:
   a. not working on a full-time basis, and
   b. depends upon you for more than 50% of his support; or
3. a handicapped child, as defined in the Continuation of Insurance for a Handicapped Child section, age 25 years or over, who was insured under this policy before reaching age 25.

The term "child" also includes a legally adopted child or child placed for adoption, stepchild, foster child, or any child who lives with you, and depends on you for more than 50% of his support.

Eligible Class means a class of persons eligible for insurance under the policy. This class is based on employment or membership in a group.

Eligible Persons means a person who:

1. is a citizen of the United States of America (U.S.) or Canada, who either:

a. resides in the U.S. or Canada; or
b. is stationed outside the U.S. or Canada for a period of less than 6 months; or

2. is a foreign national residing in the U.S. and meets all of the following requirements:
   a. has a valid permanent residency visa;
   b. participates in U.S. Social Security; and
   c. is covered by Workers' Compensation.

Employee means an eligible person who is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the policyholder or an associated company; or
4. a retiree, if listed as eligible in the policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the above conditions.

Employer means the policyholder.

Evidence of Insurability means a signed health and medical history form provided by us, a medical examination, if requested, and any additional information and attending physicians' statements that we may require.

Family Member means a person who is a parent, spouse, child, sibling, domestic partner, grandparent, grandchild, step-child, step-parent, step-sister, step-brother, father-in-law, or mother-in-law of the covered person; or spouses, as applicable, of any of these.

Full-time means working at least the number of hours indicated in the Schedule of Insurance for Full-time employment.

Gender – The use of the male pronoun also includes the female.

Home Office means the principal office of USAble Life in Little Rock, Arkansas.

Hospital means a facility supervised by one or more physicians and operated under state and local laws. It must have 24-hour nursing service by registered graduate nurses. It may specialize in treating alcoholism, drug addiction, chemical dependency, or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged.

Hospital Confined and Hospital Confinement mean staying in a hospital as a registered inpatient for 24 hours a day.

Material Duty or Material Duties mean the sets of tasks or skills required generally by employers from those engaged in an occupation. We will consider one material duty of your regular occupation to be the ability to work for an employer on a full-time basis as defined in the policy.

Noncontributory means the policyholder pays the premium.

Occupation means a group of jobs:

1. in which a common set of tasks is performed; or
2. which are related in terms of similar objectives and methodologies, and which may be related in terms of materials, products, worker actions, or worker characteristics.

Physician means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. This includes a person whom we are required to recognize as a physician by the laws or regulations of the governing jurisdiction. However, neither you nor a family member will be considered a physician.

Plan means the policy and certificates of insurance provided for covered persons.

Plan Administrator means the employer that sponsors the plan for the benefit of its employees and eligible dependents.

Policy means the group policy issued by us to the policyholder that describes the benefits for which you may be eligible.

Policyholder means the entity to which the policy is issued.

Regular Care means you personally visit a physician as often as is medically required to effectively manage and treat your disabling condition(s), according to generally accepted medical standards; and you are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the sickness or injury causing your disability must be given by a physician whose specialty or experience is appropriate.

Regular Occupation means the occupation in which you were working immediately prior to becoming disabled.

Retiree or Retirement means you begin receiving retirement benefits from either:

1. a retirement plan sponsored by your employer, the policyholder, or an associated company, or
2. a government plan.

Sickness means a disease or illness, including pregnancy.

United States of America means the fifty (50) states of the United States and the District of Columbia. It does not include territories of the United States.

Waiting Period is the number of continuous days of service during which you must be an active, full-time employee in a class eligible for insurance before you become eligible for coverage.

We, Us, and Our mean USAble Life.

You and Your mean an employee of the policyholder or an associated company who has met all the eligibility requirements for coverage, and is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the employer, or associated company covered under the policy; or
4. a retiree, if listed as eligible in the group Policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the conditions listed above.

Eligibility and Effective Date Provisions

Eligible Employee

If you are working on a full-time basis for the employer, you are eligible for insurance after completion of the required waiting period, provided you are in a class of employees who are included.

Employee Eligibility Date

If you are working for your employer in an eligible class, the date you are eligible for coverage is the latest of the following dates:

1. the policy effective date;
2. the day after you complete any waiting period shown in the Schedule of Insurance by continuous service with the employer, the policyholder, or an associated company;
3. the date the policy is changed to include your class; or
4. the date you become a member of a class eligible for insurance.

If you do not apply for voluntary coverage when you are first eligible, you will again be eligible on the first Annual Enrollment Date as shown in the Schedule of Insurance which immediately follows the date noted in items 2, 3, or 4 above.

Effective Date of Employee Insurance

You must use forms approved by us when applying for insurance.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When your Employer pays 100% of the cost of your coverage under the policy, you will be covered at 12:01 a.m. at your employer's address on your eligibility date.
2. When you and your Employer share the cost of your coverage under the policy or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. at your employer's address on the latest of the following dates:
   a. on your eligibility date, if you enroll for insurance within 31 days after the date you first become eligible for coverage; or
   b. on the first day of the policy month following the date we approve your application if you do not apply for insurance within 31 days after your eligibility date; or
   c. for voluntary coverage only, on the Annual Enrollment Date as shown in the Schedule of Insurance if you enroll during the annual enrollment period. If you do not apply for voluntary coverage during the first annual enrollment period following your eligibility date, you will be required to submit satisfactory evidence of insurability.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, your coverage will be effective on the first day of the policy month following the date we approve your application.

Delayed Effective Date

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, it will take effect on the day you return to active work. If your insurance is scheduled to take effect on a non-working day, your active work status will be based on the last working day before the scheduled effective date of your insurance.

Dependent Eligibility

Dependents are eligible for insurance on the latest of the following dates:

1. the date you become eligible for dependent insurance;
2. the date a person becomes a dependent; or

3. the date the policy is amended to include your class as being eligible for dependent insurance.

If you do not apply for voluntary dependent coverage when you are first eligible, you will again be eligible on the first Annual Enrollment Date as shown in the Schedule of Insurance which immediately follows the date noted in items 1, 2, or 3 above.

Your spouse or child will not be eligible for dependent insurance if either is insured under the policy as an employee.

If both you and your spouse are insured as employees, your eligible children may be insured as dependents of only one of you.

Effective Date of Dependent Insurance

You must use forms approved by us when applying for dependent insurance.

Dependents will not be insured until you are insured.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When your Employer pays 100% of the cost of your dependent coverage under the policy, your dependents will be covered at 12:01 a.m. at your employer's address on your dependent's eligibility date.
2. When you and your Employer share the cost of your dependent coverage under the policy or when you pay 100% of the cost yourself, your dependents will be covered at 12:01 a.m. at your employer's address on the latest of the following dates:
   a. on your dependent's eligibility date, if you enroll for dependent coverage within 31 days after the date your dependent first becomes eligible for coverage; or
   b. on the first day of the policy month following the date we approve your application for dependent coverage if you do not apply for dependent coverage within 31 days after your dependent's eligibility date; or
   c. for voluntary coverage only, on the Annual Enrollment Date as shown in the Schedule of Insurance if you enroll during the annual enrollment period. If you do not apply for voluntary dependent coverage during the first annual enrollment period following your dependent's eligibility date, you will be required to submit satisfactory evidence of insurability.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, your dependent's coverage will be effective on the first day of the policy month following the date we approve your application for dependent coverage.

You must furnish satisfactory evidence of the dependent's insurability at your own expense if you have previously terminated dependent coverage while in an eligible class.

Delayed Effective Date

Coverage for a dependent, other than a newborn child, who is confined in a hospital on the day dependent insurance or an increase in insurance is scheduled to take effect will not become effective until the 10th day following final discharge from the hospital.

Changes in Coverage Provisions

When Coverage Amounts Change (Redetermination Date)

The policy redetermines your amount of insurance on the first of the policy month after a change occurs. If benefits are based on your salary, the policyholder must report updates to all covered person's earnings as they occur. Changes to a covered person's earnings are subject to any proof of insurability requirements of the policy. As of the policy's redetermination date, we use a covered person's salary or earnings on record with us to: (a) set rates; (b) set benefit amounts and limits; and (c) calculate premium payable under the policy.

Delayed Effective Date of Change

You must be actively at work on a full-time basis on the redetermination date. If you are not, your coverage amount will not change until the date you return to active work on a full-time basis. Changes in salary or earnings will not apply to a recurring disability.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

Changes to the Policy

Any increase or decrease in coverage because of a change in the plan of insurance will become effective on the date of the change. The Delayed Effective Date provision will apply to an increase.

Termination Provisions

Termination of Employee Insurance

Your insurance will terminate at 12:00 midnight on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date the policy terminates, or the date a specified benefit terminates;
3. the date you cease to be a member of a class eligible for insurance;
4. the date you cease to be actively at work.

Continuation of Insurance

If you are unable to perform active work for a reason shown below, the policyholder may continue your insurance, except for any Accidental Death and Dismemberment coverage, on a premium-paying basis provided you remain in other respects a member of an eligible class. The continuance cannot be more than the maximum continuance shown below. The employer must act so as not to discriminate unfairly among employees in similar situations.

The maximum continuance for insurance is the longest applicable period described below:

1. six months following the date active work stopped due to lay-off or approved leave of absence, or
2. twelve months following the date active work stopped due to your total disability.

Total Disability for Continuation of Insurance means that you are under the regular care of a physician, and prevented by injury or sickness from performing all of the material duties of your regular occupation.

Termination of Dependent Insurance

Insurance on a dependent will terminate at 12:00 midnight on the earliest of the following dates:

1. the date he ceases to be a dependent as defined in the Definitions section;
2. the date you cease to be an employee or a member of a class eligible for dependent insurance;
3. the last day of the period for which a required dependent premium payment is made, if the next payment is not made; or
4. the date the policy terminates, or a specific benefit terminates.

Continuation of Insurance for a Handicapped Dependent Child

If an unmarried dependent child is not capable of self-sustaining employment due to mental or physical handicap, his insurance will not terminate at age 25. The insurance will continue as long as the child remains handicapped, unless coverage terminates as described in the Termination of Dependent Insurance section, if you give us proof that the child is:

1. incapable of self-sustaining employment; and
2. chiefly dependent on you for support and maintenance.

To keep this coverage in force, we may require proof at our expense of the child's incapacity and dependence. We may require proof from time to time, but not more than once a year after the two years that follow the date the child reaches age 25.

Claim Provisions

Notice of Loss

Written notice of claim must be given to us at our Home Office within 30 days after a loss occurs or begins, or as soon after the loss as is reasonably possible to do so, but not later than one (1) year from the time notice is required. The notice should identify the covered person and the nature of the loss.

Within 15 days after the date of your notice, we will send you claim forms. The forms must be completed and sent to our Home Office. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.

Proof of Loss

For any loss for which the policy provides periodic payment contingent upon continuing loss, written proof of loss must be given to us within 90 days after the termination of the period for which we are liable. For any other loss covered by the policy, written proof of loss must be given to us within 90 days after the date of such loss. Failure to furnish proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time. Such proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof was otherwise required.

Physical Examination and Autopsy

We have the right to have a physician of our choice examine the covered person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.

Payment of Claims

All benefits payable under this policy will be payable immediately upon receipt of due written proof of such loss.

If included, Dependent Life benefits will be paid to you. Employee Life insurance benefits will be paid to the person(s) named by you to receive them.

If you failed to name a beneficiary or if no named beneficiary is living at your death, refer to the “Beneficiary” provision below. At our option, up to the maximum allowable by the state laws of the covered person’s state of residence may be paid to any person who incurred funeral or other expenses related to the last illness or death of the covered person.

Beneficiary

Your beneficiary will be the person(s) you name in writing to receive any amount of insurance payable due to your death. The beneficiary's name is on record in our Home Office, or in the policyholder's office if the group is self-administered. You are the beneficiary of the Dependent Life Insurance if you are living. If you and your dependent die in the same accident, the dependent benefit will be paid to your estate.

You may name or change a beneficiary by giving us written notice at our Home Office (or by giving the policyholder written notice if the group is self-administered) on a form acceptable to us. When we receive the notice, it will be effective on the date made, subject to any payment we may have made before we receive it.

If there is no named beneficiary living at your death, we may pay, at our discretion, any amount due to one of the following classes of survivors: (1) your spouse; (2) your surviving children in equal shares; (3) your mother and/or father; (4) your brother and/or sister; or (5) your estate.

Assignment

You may transfer your rights to name or change the beneficiary to someone else by assignment. An assignment will affect us only if it is in writing on a form acceptable to us, and is received at our Home Office. When we record it, the assignment will take effect as of the date you made it. The assignment will be subject to any action we may have taken before we record it. We take no responsibility for the validity of any assignment.

Claims of Creditors**:** To the extent allowed by law, proceeds will not be subject to any claims of a beneficiary's creditors.

Authority

The policyholder delegates to us and agrees that we have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the policy.

We decide: (a) if a covered person is eligible for this insurance; (b) if a covered person meets the requirements for benefits to be paid; and (c) what benefits are to be paid by the policy. We also interpret how the policy is to be administered. What we pay and the terms for payment are explained in this certificate.

Limit on Legal Action

No action at law or in equity may be brought against the policy until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations has expired, but, in any case, not after three (3) years from the date of loss.

Review Procedure

You must request, in writing, a review of a denial of your claim within 180 days after you receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit written comments, documents, records and other information relating to your claim for benefits.

We will review your claim after receiving your request and send you a notice of our decision within 45 days after we receive your request, or within 90 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant provisions of the policy. We will also advise you of your further appeal rights, if any.

Subrogation and Right of Reimbursement

The plan assumes and is subrogated to your legal rights to recover any payments the plan makes for benefits, when a covered sickness or injury resulted from the action or fault of a third party. The plan's subrogation rights include the right to recover the amount of benefits paid to you.

The plan has the right to recover any and all amounts equal to the plan's payments from:

1. the insurance of the injured party;
2. the person, company (or combination thereof) that caused the sickness or injury, or any insurance company; or
3. any other source, including disability benefit coverage.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The plan's recovery will not be reduced by your negligence, nor by attorney fees and costs you incur.

Priority Right of Reimbursement

Separate and apart from the plan's right of subrogation, the plan shall have first lien and right to reimbursement. This priority right of reimbursement supersedes your right to be made whole from any recovery, whether full or partial. You agree to reimburse the plan 100% first for any and all benefits provided through the plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

1. any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from your own insurance and/or from the third party (or their insurance);
2. any auto or recreational vehicle insurance coverage or benefits including, but not limited to disability benefit coverage; and
3. business and homeowner disability insurance coverage or payments.

The plan may notify those parties of its lien and right to reimbursement without notice to or consent from any covered person.

This priority right of reimbursement will not be reduced by attorney fees and costs you incur.

The plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available disability insurance coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

Notice and Cooperation

You are required to notify us promptly if you are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable us to protect the plan's rights under this section. You are also required to cooperate with us and to execute any documents that we, acting on behalf of the policyholder, deems necessary to protect the plan's rights under this section.

You shall not do anything to hinder, delay, impede or jeopardize the plan's subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the plan to withhold any and all benefits due you under the plan. This is in addition to any and all other rights that the plan has pursuant to the provisions of the plan's subrogation rights and/or priority right of reimbursement.

If the plan has to file suit, or otherwise litigate to enforce its subrogation rights and/or priority right of reimbursement, you are responsible for paying any and all costs, including attorneys' fees, the plan incurs in addition to the amounts recovered through the subrogation rights and/or priority right of reimbursement.

Legal Action and Costs

If a covered person settles any claim or action against any third party, that covered person shall be deemed to have been made whole by the settlement and the plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. The covered person shall hold any such proceeds of settlement or judgment in trust for the benefit of the plan. The plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the covered person in such circumstances.

Additionally, the plan has the right to sue on the covered person's behalf, against any person or entity considered responsible for any condition resulting in benefits paid or to be paid by the plan.

Settlement or Other Compromise

The covered person must notify the plan prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the plan's rights so that the plan may be present and protect its subrogation rights and/or priority right of reimbursement.

The plan's subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against the covered person.

The right of subrogation and the right of reimbursement are based on the plan language in effect at the time of judgment, payment, or settlement.

The plan, or its representative, may enforce the subrogation and priority right of reimbursement.

Alternate Dispute Resolution Procedures

This dispute resolution procedure ("procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all disputes with us. Such disputes include any matters that cause you to be dissatisfied with any aspect of your relationship with us, including any claim, controversy, or potential cause of action you may have against us. Please contact the Dispute Resolution office at (800) 648-0271 if you have any questions about this section of the certificate or to begin the dispute resolution process.

The following terms are applicable to all disputes:

1. This procedure is the exclusive method of resolving any disputes.
2. The procedure can only resolve disputes that are subject to our control.
3. This procedure will be governed by the Employee Retirement Income Security Act of 1974 ("ERISA"); Rules and Regulations for Administration and Enforcement; Claims Procedure (the "Claims Regulation"). That includes the definition of an adverse benefit determination, which is defined as any denial, reduction, termination or failure to provide or make payment for what you believe should be a covered benefit.
4. You may request a form from our Dispute Resolution office to authorize another person to act on your behalf concerning a dispute.
5. We may elect to skip one or more of the steps of this procedure if it is determined that step will not help to resolve the dispute.
6. Any dispute will be resolved in accordance with the terms of this certificate, applicable state or Federal laws and regulations.
7. You must begin the dispute process within 180 days from the date you receive notice of an adverse benefit determination. If you do not initiate the dispute process within that 180 day period, you give up the right to take any action based on that Dispute.

Description of the Procedure

Inquiry

You should contact our Dispute Resolution office to discuss and attempt to resolve any issues regarding a dispute. We hope that this informal process will resolve your questions or concerns.

Appeals

If you are not satisfied with the response to your inquiry, you may submit a written request (an "appeal") to the Office of the Appeals Coordinator, USAble Life, P.O. Box 1650, Little Rock, AR 72203-1650, asking that we reconsider an adverse benefit determination. Please contact the Dispute Resolution office if you have any questions about how to submit an appeal to us. You are not required to use a specific form, but you may request that the Dispute Resolution office send you a blank appeal form to ensure that you provide the information that will be needed to review your appeal.

We will assign a coordinator to review your appeal. The appeal coordinator is an individual with appropriate expertise who is neither the individual who made the adverse benefit determination, nor a subordinate of that individual.

The appeal coordinator may request that you submit additional information concerning your grievance. The appeal coordinator will also consider information submitted by others, including information requested from other USAble Life representatives. The appeal coordinator will have full discretionary authority to make eligibility, benefit or claim determinations and construe the terms of the policy. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the policy is not governed by ERISA.

We will make a decision within 60 days after receiving your appeal concerning a claim determination.

The appeal coordinator will send you a written decision concerning your appeal. The appeal coordinator's decision will include: a statement of the coordinator's understanding of your appeal; a statement explaining the basis of the decision; and a list of the documents or information upon which that decision was based. We will send you a copy of the listed documents, without charge, if you make a written request for such documents.

Post Appeal Procedure

If you are still not satisfied after completing the appeal procedure, you have the right to bring a civil action against us to obtain the remedies available pursuant to Sec. 502(a) of ERISA (an "ERISA Action") after completing the mandatory appeal process. Those ERISA remedies will apply to this policy even if your plan is not otherwise governed by ERISA. If you agree to arbitrate a dispute, we agree to suspend (or toll) any time periods affecting your right to bring an ERISA Action against us related to that dispute, until the arbitration has been completed.

You may request that the dispute be submitted for resolution by arbitration. That arbitration request must be submitted, in writing, to USAble Life's General Counsel within sixty (60) days after you receive the appeal coordinator's decision.

The dispute will be submitted to arbitration in accordance with the rules of the American Arbitration Association, unless we both agree to use an alternative dispute resolution administrator or procedure. The arbitration will be conducted before a single arbitrator.

We will pay the filing fee charged by the administrator and the arbitrator. You will be solely responsible for any other costs that you incur to participate in the arbitration process, including your attorney's fees. The filing fee and arbitrator's fees may be reallocated as part of an arbitration award, in whole or in part, at the discretion of the arbitrator.

The arbitration will be conducted in a location where it is reasonably convenient for you to participate. If we cannot agree concerning a convenient location, the administrator or arbitrator, if appointed, shall have the discretion to decide where the arbitration will be conducted.

The arbitrator: (a) shall consider the dispute individually and shall not certify or consider multiple disputes as part of a class action; (b) shall be required to issue a reasoned written decision explaining the basis of his or her decision and the manner of calculating any award; (c) shall limit his or her decision to deciding if our adverse benefit decision was arbitrary or capricious based on ERISA standards; (d) may not award punitive, extra-contractual, treble or exemplary damages unless permitted to do so by applicable statutes or regulations; (e) may not vary or disregard the terms of the policy; and (f) shall be bound by controlling law; when issuing a decision concerning the dispute.

The arbitrator shall limit discovery to the extent possible consistent with the objective of completing the arbitration in a fair, prompt, and cost effective manner. Emergency relief such as injunctive relief may be awarded by the arbitrator.

Contact Information

General Counsel
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: [(800) 648-0271]
Email: AppealCoordinator@usablelife.com

Office of the Dispute Resolution Coordinator
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
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General Provisions

Entire Contract

This certificate is furnished in accordance with and subject to the terms of the policy. The entire contract consists of the policy, which includes the application, any amendments and addenda; this certificate; your enrollment form, if required; and any riders or endorsements. No change in the policy will be effective until approved by one of our officers. This approval can only be in writing and must be noted on or attached to the policy. No agent has authority to change the policy or certificate or to waive any of their provisions.

Any statement made by you or the policyholder is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about you or the policyholder's plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

Incontestability

Unless the premiums have not been paid, the validity of the policy cannot be contested after it has been in force for two years.

Any statement made by the policyholder or a covered person will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the covered person or the beneficiary.

No statement, except fraudulent misstatement, made by a covered person about insurability will be used to deny a claim for a loss incurred or disability starting after coverage has been in effect for two years.

No claim for loss starting two or more years after the covered person's effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Agency

Neither the policyholder, any employer, any associated company, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

Unpaid Premium

We may deduct any unpaid premium then due from the payment of a claim under this certificate.

Refund of Premium

On the death of the covered person, proceeds payable hereunder shall include the amount of unearned premium paid beyond the end of the policy month in which death occurred. Payment shall be made in one lump sum no later than 30 days after proof of the covered person's death has been furnished to us.

Conformity with State Statutes

If the provisions of this certificate do not conform with the laws of the state in which you reside on the certificate effective date, they are hereby amended to conform with the minimum requirements of the statutes of that state.

Policy Management

Efficient management of the policy requires the joint efforts of the policyholder, USAble Life, and each covered person. Each party has certain duties to bring about the effective administration of the policy.

Duties of the Policyholder: The policyholder's primary duties under the policy are listed below.

1. Give us prompt, written notice of any change in business of the policyholder and employer. This includes, but is not limited to: (a) the type of business; (b) addition or deletion of an associated company; or (c) financial status due to bankruptcy; merger; acquisition; or dissolution.
2. Give us pertinent records for all covered persons. This includes, but is not limited to: (a) hire dates; (b) eligibility dates; (c) salaries; (d) occupations; and (e) birth dates. Give us updates of such records as needed.
3. Give us prompt notice of a covered person's disability. This notice should be given as soon as possible after the date of injury or start of sickness. The most effective time for such notice is when the covered person has not been able to perform active work for 30 days.
4. Give us occupational data for all disabled covered persons. This includes, but is not limited to: (a) job descriptions and analyses; and (b) environmental factors.

Duties of Covered Persons and Beneficiaries: Your and your beneficiary's primary duties under the policy are listed below:

1. Give notice and proof of loss as soon as possible after the date of your injury or sickness, or the date of your death, or the death of a covered dependent, if applicable.
2. Give a complete account of the details of your injury or sickness or the death on a form approved by us.
3. Provide any other official documents to review the loss such as a certified death certificate, investigating officer's report, or medical records.
4. Allow release of medical and income data needed to adjudicate your claim.
5. Provide evidence of the regular care of a physician, if necessary.
6. Promptly report to us any changes in your status such as your address or telephone number, or if you return to work or are no longer disabled.
7. If benefits are overpaid, reimburse such overpayment within 60 days of the date benefits were overpaid.
8. Provide proof of your earnings for the period prior to a loss.

Fraud

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the policy and recovery of any amounts we have paid.

Employee Term Life Insurance

Death Benefit

We will pay your beneficiary the amount of insurance in force on the date of death, as shown in the Schedule of Insurance, when we receive all required proof of loss, including written proof of your death acceptable to us and a completed claim form.

Suicide

This provision applies to Voluntary Life only. If you, whether sane or insane, die by suicide within one year(s) of your original effective date of insurance, the death benefit will be limited to the amount of premiums paid for your insurance.

After having been insured for one year(s), if you, whether sane or insane, die by suicide within one year(s) of the effective date of an increase in coverage, the death benefit will be limited to the amount of insurance in effect prior to the increase in coverage, plus the amount of premiums paid for the increase in coverage.

With respect to employees insured on the effective date of the policy:

1. if the policy replaces another group life policy, the one year(s) limitation on death by suicide shall be reduced by the number of months you were continuously insured by the prior policy; and
2. the benefit payable shall be the lesser of the amount otherwise payable under this policy or the amount provided by the prior policy.

Conversion Privilege for Life Insurance

Conversion upon Termination of Employment or Eligibility

For Employees

You may convert all or part of your life insurance to an individual policy of life insurance, other than Term,

1. if all or part of it stops for any reason; unless
2. it stops because you did not pay any required premiums.

The amount you may apply for may not be more than:

1. the life amount then in force; or
2. that part of the life amount which has stopped, whichever is less.

Accidental death and dismemberment, disability or any other supplemental coverage for which you are eligible under this policy may not be converted.

For Dependents

Your covered dependent spouse or child may convert all or part of his life insurance to an individual life policy, other than Term, if the insurance on his life ends because:

1. you stopped working full-time for your employer; or
2. you ceased to be a member of a class eligible for insurance; or
3. the dependent ceased to be an eligible family member; or
4. of your death.

Conversion upon Termination or Amendment of Group Policy

Any covered person may convert a limited amount of life insurance if he has been continuously insured under the policy for at least five (5) years and his insurance ends due to termination or amendment of the policy.

The amount you may convert in this case is the smaller of the following:

1. the amount of life insurance which terminates, less the amount you became eligible for under any group policy within 31 days after this insurance terminated; or
2. $10,000.

Conversion Coverage

Any covered person may convert his life insurance to any policy we are issuing for the purpose of conversions other than Term. The conversion policy will not have disability or other supplementary benefits. No evidence of insurability will be required. The premium will be based on the amount and the form of the conversion policy, and on the covered person's class of risk and age on the date the conversion takes effect.

A conversion policy is in lieu of all other benefits under this policy. If you qualify for the Extended Insurance Benefit, any conversion policy issued will be canceled. Premiums paid for the converted policy will be returned.

The conversion policy will take effect on the 32nd day after the insurance terminates.

Notice and Application Required

Written application and the first premium payment for the conversion policy must be received in our Home Office within 31 days after the covered person's insurance terminates. If you are not given notice of the right to convert by the 16th day of the 31 day conversion period, you will have an additional period in which to apply for conversion. The additional period will end 15

days after you are given notice, but not more than 61 days after the date the insurance under the policy ended.

Nothing in the policy will continue coverage for more than 31 days following the date coverage ends under the policy. Written notice, contained in this certificate of insurance and given to you at any time, or mailed by the policyholder to your last known address will be considered sufficient written notice to you. It is the responsibility of the policyholder to give such notice to you.

Conversion Period Death Benefit

If the covered person dies within the 31 days allowed for making application to convert, we will pay the amount he was entitled to convert. We will do this whether or not application was made.

Life Insurance – Portability

This section applies to the Voluntary Life Insurance Benefit only.

Portability Benefit

You may continue your and your spouse's voluntary term life insurance if your employment terminates and you meet the following requirements on the date your employment terminates:

1. you are not disabled; and
2. you either:
   a. are not retired and are under age 70; or
   b. you are retired and are under age 65.

Coverage will be continued under the policy for employees who elect continuation of coverage under this portability provision. Portability is not available upon policy cancellation.

Your spouse's term life insurance may not be continued if your term life insurance is not continued. Dependent children are not eligible for the Portability provision; however, the dependent children's coverage may be converted under the "Conversion Privilege" provisions of the policy.

"Retired" means you are a former employee who has begun receiving one of the following:

1. retirement pension benefits under any plan of a federal, state, county or municipal retirement system, if such pension benefits include any credit for employment with the policyholder;
2. retirement pension benefits under any plan which the policyholder sponsors or makes or has made contributions; or
3. retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act.

Application and Premium Payment

You must apply for portability in writing to USAble Life within 31 days after the date your employment ends.

You must pay the required premium quarterly, semi-annually, or annually directly to USAble Life. The premium rate will be determined by us. The first premium payment must be made no later than 31 days after the date the insurance would otherwise terminate under the policy.

Amount of Insurance

The amount of insurance that you and your spouse may continue is the amount in effect on the date your employment terminates. The reduction and termination provisions stated in the Change Rider – Portability will apply to insurance continued under this provision.

When Portability Ends

Your continued coverage under this provision will end automatically on the earliest of the following:

1. the date the last period ends for which you made a premium payment;
2. the premium due date after the covered person has continued coverage under this provision for 3 year(s);
3. the premium due date following your attainment of age 70;
4. if your coverage continued due to your retirement prior to age 65, on the premium due date following your attainment of age 65;

5. the date you become a full-time member of the armed forces of any country; or
6. spouse coverage will end on the premium due date following the date the spouse ceases to be a dependent as defined in the policy, or
7. spouse coverage will end on the premium due date following the spouse's attainment of age 65.

When your insurance under the portability provision ends, you and your spouse will be eligible to convert your insurance to an individual policy under the "Conversion Privilege" provisions.

Coverage continued under the portability provision is in lieu of all other benefits under the policy, including conversion. If you return to work with the employer and again become eligible for Term Life coverage under the policy, continued coverage under the portability provision will cancel on the date coverage is resumed under the policy.

Other Policy Provisions

The Life Insurance – Waiver of Premium and the Group Life Accelerated Benefit provisions will not apply to insurance continued under the Portability provision.

With respect to any notice you are required to provide to the employer under other provisions of the policy, you must provide such notice to USAble Life while the insurance is continued under the Portability provision.

Dependent Term Life Insurance

Death Benefit

We will pay the amount of insurance in force on the date of death, as shown in the Schedule of Insurance, when we receive all required proof of loss, including written proof of your covered dependent's death acceptable to us and a completed claim form.

Suicide

If a covered dependent, whether sane or insane, dies by suicide within one year(s) of his original effective date of insurance, the death benefit will be limited to the amount of premiums paid for this insurance.

After having been insured for one year(s), if a covered dependent, whether sane or insane, dies by suicide within one year(s) of the effective date of an increase in coverage, the death benefit will be limited to the amount of insurance in effect prior to the increase in coverage, plus the amount of premiums paid for the increase in coverage.

With respect to dependents insured on the effective date of the policy:

1. if the policy replaces another group life policy providing similar dependent life insurance, the one year(s) limitation on death by suicide shall be reduced by the number of months you were continuously insured for dependent life by the prior policy; and
2. the benefit payable shall be the lesser of the amount otherwise payable under this policy or the amount provided by the prior policy.

Group Life Accelerated Benefit

This section applies to the Voluntary Life Insurance Benefit only.

Notice of Possible Tax Consequences

Please be advised that receipt of the accelerated benefits may be taxable. Any person who receives accelerated benefits should consult his personal tax advisor.

The receipt of accelerated benefit payments may adversely affect the covered person's eligibility for Medicaid or other government benefits or entitlements.

Definitions

"Terminal Illness" means a medical condition:

1. which is expected to result in the covered person's death within 12 months; and
2. from which the covered person is not expected to recover.

Eligibility

All covered employees and covered dependents under age 70 who are insured for a minimum of $10,000 of life insurance under the policy are eligible.

A covered employee or dependent is eligible for the accelerated benefit only if he becomes and remains insured for life insurance under the policy.

Accelerated Benefit

The accelerated benefit is an advance payment to the covered person who:

1. is terminally ill; and
2. elects to receive part of his life insurance benefit payable under the group policy, subject to the maximum benefit amounts stated on the Schedule of Insurance.

We will pay an accelerated benefit to you when we receive the following:

1. a written request for payment of the accelerated benefit; and
2. proof that the covered person is terminally ill and his illness is expected to result in his death within 12 months.

The accelerated benefit will be paid only once for each eligible covered person, and in one lump sum to you before death occurs.

Cost of Providing the Accelerated Benefit

There is no cost associated with providing the accelerated benefit.

Amount of Accelerated Benefit

The maximum accelerated benefit will be the lesser of:

1. 75% of the covered person's life insurance amount; or
2. $250,000.

If the covered person's life insurance amount is scheduled for a reduction within 12 months after the date you request the payment of the accelerated benefit, the maximum accelerated benefit will be based on the reduced amount.

Irrevocable Beneficiary

For the purpose of the Accelerated Benefit provision, an irrevocable beneficiary is a named beneficiary whose rights to the employee's life insurance proceeds are vested and whose rights cannot be cancelled by the employee unless the irrevocable beneficiary consents.

Conditions and Requirements for Payment of the Accelerated Benefit

You must request payment of an accelerated benefit in writing.

Proof that the covered person is terminally ill must be provided to us. The proof must be certified by a licensed physician and in a form that is satisfactory to us. We are not obligated to ask for any proof. Any delay in submitting proof will not cause a request to be denied if the proof is given to us as soon as reasonably possible.

After receipt of such proof, we may require the covered person to be examined by a licensed physician of our choice, at our expense. If there is a disagreement between the two physicians, we may require the covered person to be examined by another licensed physician of our choice, at our expense. The decision of the third physician will be final.

Effect of Payment of an Accelerated Benefit on Policy Provisions

The covered person's amount of life insurance under the policy will be reduced by the amount of any accelerated benefit that has been previously paid.

The following will be based on the reduced life insurance amount:

1. the amount of life insurance payable to the beneficiary when the covered person dies;
2. the amount of life insurance the covered person can convert under the policy; and
3. the premiums payable for the covered person's life insurance under the policy after an accelerated benefit is paid to you, if such premiums are not waived.

Exclusions

We will not pay an accelerated benefit if:

1. the covered person has made an absolute assignment of his life insurance under the policy and we do not receive written consent by the absolute assignee;
2. all or part of the covered person's life insurance under the group policy is to be paid to his children or former spouse as part of a court approved divorce agreement;
3. the covered person has made an irrevocable beneficiary designation of his life insurance under the policy and we do not receive written consent by the irrevocable beneficiary; or
4. the terminal illness is a result of intentional self-inflicted injury or attempted suicide, committed while sane or insane.

Date Insurance Ends under this Benefit

A covered person's insurance under this benefit will end at the earliest of:

1. the date the accelerated benefit is paid to you on the covered person's behalf;
2. the date the covered person's life insurance ends under the policy; or
3. the policy anniversary on which the covered person is age 70.

Important Notice

The following information is provided to assist you in answering any questions you might have:

Soliciting Agent
The name, address and telephone number of our soliciting agent is available to you, if needed, by calling our Customer Service Department at [(800) 370-5856].

USAble Life

USAble Life
P. O. Box 1650
Little Rock, AR 72203-1650
Toll Free [(800) 370-5856]

If we fail to provide you with reasonable and adequate service, you may contact:

Arkansas Insurance Department

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Phone (501) 371-2640 or
Toll Free 1-800-852-5494

We appreciate the opportunity to serve your insurance needs.

ERISA Information

Plan Sponsorship and Administration

The plan was established by the actions of your employer, which continues to act as Plan Sponsor and Plan Administrator. Your employer, as Plan Administrator, performs the functions of distributing Plan notices and information to employees and other Plan participants, coordinates employees' and eligible dependents' enrollment in the Plan, and transmits Plan premium payments.

ERISA Rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.
4. Neither your employer, nor any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
5. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
6. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, provided that you have first followed the Plan's designated appeals procedure before bringing suit.
7. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees.
8. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
9. If you have any questions about your Plan, you should contact the Plan Administrator.
10. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

SERFF Tracking Number:	*LSVX-G127678989*	*State:*	*Arkansas*
Filing Company:	*USAble Life*	*State Tracking Number:*	*49937*
Company Tracking Number:	*AR000780100013*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Group Policy, GRP-P - Simmons First National Bank*		
Project Name/Number:	*Group Policy, GRP-P/AR000780100013*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

AR - READABILITY CERTIFICATION.PDF

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

See filing description for approval information

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **USAble Life**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
GRP-SIMMONS-P (5-09)	51.4
GRP-SIMMONS-CL1 (5-09)	51.6
GRP-SIMMONS-CL2 (5-09)	51.6
GRP-SIMMONS-CL3 (5-09)	51.6
GRP-SIMMONS-CL4 (5-09)	51.6
GRP-SIMMONS-VADD-CL1 (5-09)	51.6
GRP-SIMMONS-VADD-CL2 (5-09)	51.6
GRP-SIMMONS-VADD-CL3 (5-09)	51.6
GRP-SIMMONS-VGTL-CL1 (5-09)	51.6
GRP-SIMMONS-VGTL-CL2 (5-09)	51.6
GRP-SIMMONS-VGTL-CL3 (5-09)	51.6

Signed: 

Name: Connie Phillips

Title: Assistant General Counsel & Assistant Secretary

Date: 10/3/2011